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CONTRACTING ACTIVITIES OF HMO's & STATE MEDICAID AGENCIES

CONTRACTING ACTIVITIES

OF HMO's & STATE MEDICAID AGENCIES

Pre and Post OBRA 1981

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The completion of this project has been the result of combined efforts and cooperation of many different individuals and organizations. Roger McClung, Ph.D., has served as Project Officer throughout most of the study and has provided invaluable support and direction. During the earlier stages of the project Lois Eberhard and Janet Sadler served as Project Officers. Site Visits were made to four States: Maryland, Michigan, Pennsylvania and Wisconsin. The State Medicaid Agencies were visited in each of these States and HMOs in Michigan (Comprehensive Health Services, Group Health Plan of Southeast Michigan, Michigan HMO Plans, Inc). and in Wisconsin (Health Plus, Sumaritan Health Plan, TotalCare Health Plan, Inc.) were visited. These site visits were instrumental in the development of the study methodology. Thirty State Medicaid Agencies and 34 HMOs participated in the study for a response rate of 97 percent. Three members of the BHMORD staff, Dwight Blankenbaker, Bob Hamel, and Beth Roy, served as a review panel and contributed to the quality of the final report.

EXECUTIVE SUMMARY

OVERVIEW

This study was commissioned by the Health Resources and Services Administration, Department of Health and Human Services to examine the impact of the 1981 Omnibus Budget Reconciliation Act (OBRA) legislation on HMO/Medicaid contracting. The legislative changes that were examined included:

- Section 1915(b) of the Social Security Act (OBRA 2175)- Waivers of State Plan requirements affecting the freedom of Medicaid enrollees to choose providers of health care services.
- Section 1903(m) of the Social Security Act (OBRA 2178)- The expansion of the definition of HMOs eligible to contract with States under the Medicaid Program to include State-qualified HMOs.
- Section 1902(3)(2)(B) of the Social Security Act (OBRA Section 2178)- The guaranteed eligibility provision which provides State Medicaid Agencies the option of continuing Medicaid enrollment for an enrollee for a period of up to six months in a Federally qualified HMO, even if the enrollee loses Medicaid eligibility before the end of that period.

The basic goal of the study was to help States and HMOs improve their contracting relationships, thereby increasing the enrollment of Medicaid recipients in HMOs. The underlying objectives of this goal were:

- To describe the basic characteristics of HMO/State Medicaid Agency contracting.
- To examine the effect of legislative changes in the relationship between Medicaid Agencies and HMOs.
- To document the processes used by State Medicaid Agencies/HMOs to achieve successful working and contracting arrangements.
- To assess the impact of Medicaid waivers, State-qualified HMOs, and guaranteed enrollment periods on Medicaid enrollment in HMOs.
- To assess the impact of the legislative changes on reducing or eliminating barriers to State Medicaid Agency/HMO contracting.

The findings of the study provide information to the Department of Health and Human Services, to HMOs, and to State Medicaid Agencies.

STUDY DESIGN

In this descriptive study, thirty States were evaluated on their implemented OBRA legislation and their HMO contracting activities as of September 1984. The date of September 1984 had no particular significance other than to serve as a cut-off point in time. States and HMOs were divided into seven distinct groups: (1) States with a 2175 waiver that contract with HMOs; (2) States with extended eligibility; (3) States that contract with State-qualified HMOs; (4) States with no HMO contracts under the 2175 waiver but which contract with HMOs; (5) States with OBRA legislative authority but no HMO contracts; (6) States with no OBRA legislative authority that contract with HMOs; and (7) States with no OBRA legislatve authority and no HMO contracts.

Initially, site visits were made to four States in order to become more familiar with HMO/Medicaid contracting and to refine the survey instruments used for the conduct of the telephone survey. Upon completion of the site visits, telephone interview guides were developed for State Medicaid Agencies and for HMOs in each of the seven groups. Most of the questions on the guides were open-ended and the interviewer probed in order to get complete information.

DATA COLLECTION

Data for the study were analyzed for the 30 State Medicaid Agencies and the interviewed HMOs in those States. These data included the OBRA 1981 legislative authority used, number of State contracts with HMOs, Medicaid eligibility group served, Medicaid enrollment in HMOs, and type of enrollment. Data were also collected on impetus to contracting, contract development, contract monitoring, reimbursement, results, barriers, eligibility notification, marketing, HMO benefit package, 75% rule, turnover, and reporting requirements.

STUDY FINDINGS

This study was initially designed to examine seven groups of Medicaid Agencies and HMOs, five groups of States that had implemented OBRA legislative authorities and two groups of States that had not implemented OBRA legislative authorities. The detailed tables and analyses address these groups. However, in the final analysis there appear to be few differences in the responses among the groups or even between State Medicaid Agencies/HMOs using OBRA legislative authorities and those not using OBRA legislative authorities. Thus, most of our findings relate to Medicaid/HMO contracting in general. Out of the forty-eight continental States and the District of Columbia, only fourteen States had used OBRA legislative authorities in conjunction with HMO/Medicaid contracting. Three State Medicaid Agencies used the 2175 waiver with HMO contracting, five had extended eligibility, and nine contracted with State-qualified HMOs.*

1. Descriptive Characteristics

Thirty State Medicaid Agencies and at least one HMO in each of those States were surveyed. The States were divided into two basic groupings--those States where the State Medicaid Agency uses OBRA 1981 legislative authority and those States where the State Medicaid Agency does not use OBRA 1981 legislative authority. The table below describes the most common characteristics found of HMO/Medicaid Agency contracting among the thirty States and breaks out the activities according to whether the States have or do not have OBRA legislation. The table shows essentially the same results as those States with OBRA or no OBRA legislation:

HMO/Medicaid Characteristics	%Total States (n=30)	% with OBRA (n=20)	% with no OBRA (n=10)
HMOs serve multiple counties	75	75	71
HMOs serve AFDC only	50	53	43
Enrollment in HMO is voluntary	85	85	86
Marketing is HMO/Medicaid cooperative effort	65	85	29
Rates negotiated or set by State	90	85	100

Marketing in the States with no implementation of OBRA legislative authorities has been done primarily by the State Medicaid Agency only rather than in conjunction with HMOs as in the OBRA States.

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*Two States used more than one of the three legislative authorities.

2. Processes

Six major processes used by the twenty contracting HMOs and State Medicaid Agencies were examined. The six processes and the results show the following:

Eligibility - Medicaid provides medical assistance to groups of people who qualify under one of the cash assistance programs of the Social Security Act or who qualify as medically needy. In contracting with HMOs, State Medicaid Agencies most frequently choose to contract only for services to the enrollees who qualify under the Families with dependent Children (AFDC) program. This results in HMOs providing services for the group of Medicaid eligibles that are generally more healthy than other groups. The procedures for informing the HMO of the Medicaid member's eligibility vary between the State Medicaid Agencies, but there are generally two ways that members enroll and are determinined eligible. One way is that the Medicaid eligible enrolls in the HMO, which then verifies eligibility with the State Medicaid Agency. The second way is that the individual enrolls at the Medicaid eligibility office, which then notifies the HMO of the member's enrollment and eligibility. The time period varies among Medicaid Agencies as to how often the HMOs are updated on Medicaid eligibles. Only three States (HMOs/Medicaid Agencies) stated that there was a significant time lag between HMO enrollment and the time when the recipient could use HMO services.

Benefits - HMOs are required to make their services available to Medicaid enrollees to the same extent Medicaid services are available from other sources to nonenrolled Medicaid recipients in the area. Forty percent of the HMOs offered more services (i.e. health education and promotion classes) than the complete Medicaid benefit package and 35 percent offered the same package. Services not provided by HMOs were covered with fee-for-service (FFS) in 86 percent of the cases, and either contracted by the HMO or by the State Medicaid Agency in the remainder of the cases.

Reimbursement - Capitation rates ranged from $13.52 to $285.80 per month per recipient. This broad reimbursement range can be attributed to the fact that HMO/Medicaid contracts cover different eligibility groups and contracts include different services depending on the services in the State Medicaid Program benefit package and the services which the HMO contracts to provide. In order to accommodate these variations when State Medicaid Agencies and HMOs were negotiating/setting capitation rates, various factors were used including: eligibility group, geographic location, age, and sex. In almost all States, capitation rates were either negotiated between the HMOs and the State or set by the State. In approximately three-fourths of the States, rates were based on FFS and used eligibility groupings and geographic groupings to determine the rates. Full risk was assumed by 75 percent of the HMOs, stop-loss agreements were in

60 percent of the contracts, State provided reinsurance was provided in only six out of 20 States, and dummy claims were submitted by HMOs in only four States.

Contract Development - Approximately 60 percent of the contracts used by the HMOs and State Medicaid Agencies were based on a standard State model developed by each State. Contracting was initiated more successfully when the political environment within the State encouraged contracting. In over 50 percent of the HMO/State Medicaid Agency contracts, the impetus to contracting was given by the State Medicaid Agency, State legislature, or combined State/HMO. In 25 percent of the States, the HMO was responsible for initiating the contracting process and in the remaining 25 percent, an outside influence (i.e. national study) was responsible.

Contract Monitoring - State Medicaid Agencies usually limit their monitoring activities to reporting requirements and on-site visits/audits. Ninety-five percent of the State Medicaid Agencies have reporting requirements for the HMOs with 95% of the agencies also conducting site visits.

Marketing - The most common marketing approach in the States was a cooperative effort between the State Medicaid Agency and the HMO. Marketing tools most used by HMOs/Medicaid Agencies were brochures (used by 75%) and mass mailings (used by 40%).

3. Barriers

While there were no significant differences in the barriers to HMO/Medicaid contracting reported by States implementing OBRA legislation compared to States with no implementation of OBRA legislation, there were differences between the numbers of barriers perceived by the State Medicaid Agencies and those perceived by the HMOs. Eighteen HMOs reported a total of 76 barriers while 20 State Medicaid Agencies reported a total of only 30 barriers - an average of 4.2 barriers reported per HMO to and average of 1.5 barriers reported per State. Barriers perceived most frequently by State Medicaid Agencies included the 75% Rule (35%), Contracting (25%), Medicaid Clients Considered Stigma (25%), and Other (60%). HMOs mentioned Turnover of Medicaid Clients (67%), Marketing (61%), Eligibility Determination (61%), Reimbursement Rates (56%), Slow Payment (39%), and Administrative Requirements (39%).

As each contracting situation is unique, it is difficult to determine if, and to what extent, the OBRA legislation is a contributing factor in reducing the problems encountered in HMO/Medicaid contracting. The legislation, especially the expansion of the definition of HMOs eligible to contract with Medicaid to include State-qualified HMOs, did allow and encourage more HMO/Medicaid contracts to develop, but how the legislation reduces barriers to contracting, can not yet be determined.

4. States Without HMO/Medicaid Contracts

Ten States without HMO/Medicaid contracts were contacted regarding plans of both the Medicaid Agencies and HMOs for contracting. HMOs and State Medicaid Agencies in four States agreed that they had current and/or future plans for HMO/Medicaid contracting. Three other State Medicaid Agencies Stated that they had plans to contract in the future, but the interviewed HMOs in these three States did not plan to contract. The reasons that the State Medicaid Agencies gave for not contracting included that the Medicaid Agency was concentrating on other things (4), the HMO requirements were unacceptable (2), the geographic locations of the HMOs were not good (2), HMO contracting does not work (2), HMOs are not interested (1), and HMOs do not provide the level of care needed (1). HMOs' reasons for not contracting were: they were concentrating on other clients (6), they do not contract with the public sector (2), they are unfamiliar with the Medicaid population (2), and the State Medicaid Agency was not willing (1).

5. Enrollment

Medicaid enrollment in HMOs increased over the most recent two years for which data were available for almost all States whether the State Medicaid Agency had implemented OBRA legislation or not. Utah and Washington both showed an insignificant decrease of 1.5% (less than 100 people) while Indiana showed a larger decline (27.7%). Actual enrollment figures for 1983 compared to the most current year for which enrollment figures are available (1984 or 1985) increased from 176,404 to 324,385 - an increase of 84 percent. States using OBRA legislation increased enrollment ten times more than the States not using OBRA legislation. This difference can be explained principally by the fact that States using OBRA legislation were more likely to have just begun HMO/Medicaid contracting while the States not using OBRA legislation already have established HMO/Medicaid enrollments. For example, in Wisconsin, where OBRA legislation is used, over 100,000 enrollees were added to the HMO rolls through their mandatory choice program.

CONCLUSIONS

This report is a compilation of the HMO/Medicaid contracting activities and not an evaluation of the effectiveness of the contracting process. Each HMO/Medicaid Agency is unique and what is effective for one may not be so for another. The effectiveness of the HMO/Medicaid contract lies in the established objectives and goals of the HMO and the Medicaid Agency. For example, for one HMO, their intention may be to serve just 10 percent of the Medicaid population in order to fulfill their committment of serving a cross section of the population. On the other hand, another HMO may view their

HMO/Medicaid contract effective only if they are able to serve all Medicaid eligibles in their service area.

As previously mentioned, contracting was initiated more successfully when the political environment within the State encouraged contracting. The political environment of the State appeared more closely related to the success of HMO/Medicaid contract than to any recent changes in legislation. Generally, when the State Administration supported and encouraged HMO contracting, the contracting was implemented in a timely manner, there were fewer problems, and there was greater success in terms of Medicaid enrollment. In some States, HMOs have approached State Medicaid Agencies about contracting but this usually has been a much slower process.

HMO/Medicaid contracting and the implementation of OBRA legislative authorities is never stagnant. Changes are being considered by some States and are being implemented by other States. It was found that no matter what arrangement the States and HMOs have, they can learn from the experience of others as to the most effective ways to impact HMO/Medicaid contracting.

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CHAPTER ONE
INTRODUCTION

Over the past decade, total Federal-State Medicaid expenditures have grown at an average annual compound rate of growth of 16.9 percent to a total expenditure level of $34.3 billion in FY 1984. Growth in Medicaid outlays has greatly exceeded growth in Federal or State revenues. This increase in Medicaid expenditures, against a backdrop of Federal and State governments' fiscal problems and changing Federal priorities, has put a squeeze on State and local governments in health and welfare programs. In response to the escalating Medicaid costs, Congress enacted legislation to give States greater flexibility to control costs and to manage State Medicaid programs more effectively. Some of these provisions had the potential for increasing the enrollment of Medicaid enrollees in HMOs. It is the impact of these provisions that is the subject of this study. This chapter gives a summary of the HMO Program and the Medicaid Program and examines legislation concerning Medicaid/HMO contracting.

A. HMO PROGRAM IN PERSPECTIVE

HMOs were first developed on a large scale around the turn of the 19th century. The first examples of this concept were in Washington and Oregon with groups in Texas and Oklahoma developed in the late 1920s. Also, in 1929 Drs. Donald Ross and H. Clifford Loos began a controversial prepaid program to provide medical coverage to the Los Angeles water and power department employees. This prepaid program and others that were soon to follow faced difficult times as many people opposed their existance.

In response to this controversy, a five-year study known as the 1932 Committee on the Costs of Medical Care Report was conducted. This report entertained the idea of voluntary enrollment in hospital-based prepaid group practice plans. Also, at this same time, the American Medical Association (AMA) made known their strong opposition to prepaid medical care.

Although prepaid practices faced many difficulties, they continued to expand. In 1937, Group Health Association, the first urban forerunner of HMOs, signed up its first enrollees in Washington, D.C.. On the West Coast, the Kaiser Company, which was later to become known as Kaiser-Permanente and the largest HMO in the country, was established. The 1940s and 1950s saw the development of many more prepaid group practices, two of the more well-known ones being the Health Insurance Plan

(HIP) of Greater New York and the Group Health Cooperative of Puget Sound.

Although prepaid group practices were growing around the country and faced less conflicts in the 1960s and early 1970s, their market remained limited primarily because Americans were not educated or familiar with what prepaid practices had to offer. This changed however, in the early 1970s, when Dr. Paul Ellwood was instrumental in convincing the Nixon Adminstration to adopt the "health maintenance organization," his new term for a prepaid practice, as the answer to our country's concern over rising health care costs in the private and public sector. Even though the Nixon Administration strongly supported the HMO concept, there was difficulty in getting legislation passed until 1973. In 1973, the Health Maintenance Act was approved.

The 1973 HMO Act was passed to foster HMO development in accordance with Federally-prescribed minimum benefits and other organizational requirements. Initially, $55 million was appropriated to develop HMOs until they became financially self-sufficient. Two mechanisms were used to distribute these funds:

- Three types of grants were given to organizations wanting to plan and develop an HMO:
    - Feasibility grants to determine HMO viability in a particular community;
    - Planning grants to hire core staff and begin the planning process after demonstrating feasibility; and
    - Initial development grants to complete planning activities, prepare for Federal qualification, and bring the plan to operation.
- Loan support to the level of $55 million was made available to Federally-qualified non-profit HMOs to cover operating losses.

The Federal HMO program was established to implement the Act. Now, after several reorganizations, the Office of Health Maintenance Organizations (OHMO), Department of Health and Human Services (DHHS), has evolved into three functional divisions reporting to a single Director. Recent changes in OHMO's functions reflect the maturation of the HMO industry since the office was first formed. For example, the grant program as well as OHMO's Regional Offices no longer exist.

Although HMO growth has not been what was predicted in the early 1970s, HMOs have made and are continuing to make a strong impact on our health care delivery system. Since 1973, the number of operational Federally-qualified HMOs reached 256 and enrollment climbed to over 13 million in April 1985. The figures present a substantial increase in HMO growth since 1971 when 39 HMOs had 3.5 million enrollees.

The success of the Federal initiative and CHMO efforts have also stimulated ever-increasing private investment in HMOs. Insurance companies, Blue Cross/Blue Shield plans, and private corporations are involved in developing and acquiring HMOs. As of December 1984. there were 99 operational HMOs affiliated with 23 national HMO firms with an aggregate enrollment of over 9 million members.

B. MEDICAID PROGRAM IN PERSPECTIVE

The Medicaid Program, created in 1965 as Title XIX of the Social Security Act was designed as a Federal and State supported assistance program providing medical care for certain low income individuals and families and was to be administered at the State level. Medicaid accounted for over $34.3 billion in Federal and State expenditures in Federal fiscal year 1984, and is the primary source of health care coverage for the poor in America. The program is designed to provide medical assistance to those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. In addition, States may provide Medicaid to the "medically needy," that is, to people (1) who fit into one of the categories of people covered by the cash assistance programs and (2) who have enough income to pay for their basic living expenses (and so are not recipients of welfare), but not enough income to pay for their medical care.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services for individuals 21 and older, home health care services, physicians' services, family planning services, rural health clinic services, early and periodic screening, diagnosis, and treatment services for individuals under 21, and nurse-midwife services. In addition, States may provide a number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, and dental care.

Medicaid operates as a vendor payment program. Payments are made directly to providers of service for care rendered to eligible individuals. Providers must accept the Medicaid reimbursement level as payment in full. In medical institutions and intermediate care facilities, individuals are required to turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. States may require Medicaid recipients to pay cost sharing on services. Most State Medicaid programs have buy-in agreements with Medicare and under these agreements, Medicaid assumes responsibility for the Medicare cost-sharing obligation of persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' per capita income and currently range from 50 percent to 77.36 percent of program medical expenditures. Administration and Medicaid Management Information System (MMIS) costs are matched at other rates. States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs. The District of Columbia, Puerto Rico, Guam, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. As a result, the characteristics of Medicaid programs vary considerably from State to State.

Due to the success of HMOs in the private sector and concern over current rising health care costs, the government began to consider the potential of HMOs as providers of health care services in the public sector. Congress and the Health Care Financing Administration (HCFA) have taken action steps that include the increased use of HMOs. HCFA currently is conducting demonstrations involving HMO participation in Medicare and Medicaid. In 1981, the Omnibus Budget Reconciliation Act (OBRA) made a number of changes in Federal law which gave State Medicaid Agencies more flexibility in contracting with HMOs.

C. HMO/MEDICAID CONTRACTING LEGISLATION

The legislative authority for State Medicaid Agencies (State MAs) to contract with HMOs is contained in Section 1902(a)(23) of the 1967 Amendments to the Social Security Act (Section 227(e)(3)). Known as the "freedom of choice" provision, it recognizes an "organization which provides services, or arranges for their availability on a prepayment basis."

Regulations for implementing this legislation provided little guidance other than (1) the State MA specify the amount of the premium, the services covered, and the term of the contract; (2) the premium payment fully discharges the State MA from responsibility for the costs of the covered services; (3) the premium amount and/or covered services be periodically renegotiated; and (4) the State MA require the prepaid health plan to maintain and provide such records and reports necessary for the State MA to meet Federal reporting requirements. The State MA, in order to obtain Federal sharing, had to pay the plan premiums which would not exceed the cost of providing the same services under the fee-for-service system. Prior DHHS approval of HMO contracts was not required. The 1972 Amendments to the Act amended Section 1902(a)(23) to allow State MAs to contract with an organization to provide care and services in addition to those under the State plan in a sub-State area, thereby avoiding conflict with the statewide and comparability provisions of the law.

Twelve States Medicaid Agencies (MAs) signed 66 contracts with HMOs between 1971 and 1973 to serve a total Medicaid enrollee population of 371 thousand. However, within the first year of this program in California, serious complaints were raised about the cost, quality, enrollment practices, and corporate accountability of the plans contracting with the State Medicaid Agency. As a result of those problems, regulations were finally published on August 9, 1975 placing a number of new requirements on State MA contracts with HMOs. These included (1) that the State MA control HMO enrollment and disenrollment practices; (2) that services be available on a 24 hour, seven days a week emergency basis; (3) that internal grievance procedures be established; and (4) that a medical record-keeping system exist. The regulations also expanded access to records requirements by stipulating that the State MA and the DHHS have the right to inspect and evaluate the quality, appropriateness, and timeliness of services provided and audit and inspect any books and records of the HMO which relate to the contract. The State MA also had to provide DHHS with the actuarial basis for the premium determination, and the Department required prior approval of contracts with expected values $100,000 or more.

The HMO Amendments of 1976 went further toward correcting the conditions which permitted the scandals in California to occur. Title XIX matching funds were limited to Federally qualified HMOs with few exceptions, and qualified HMOs were restricted from enrolling more than 50 percent of their members from Medicare and Medicaid. Also the 1976 amendments permitted State MAs to contract with non-qualified HMOs under limited defined circumstances or for a three year period when the plan was seeking Federal qualification. Prior to the enactment of OBRA 1981, Medicaid recipients were allowed to determine not only when care would be sought but also how often. This right could be limited only when a State received a Section 1115 waiver from the Secretary in order to demonstrate an innovative approach to the delivery and financing of services to Medicaid recipients.

Section 2175 of OBRA 1981 made it easier to obtain waivers of the "freedom of choice" by modifying Section 1915(b) of the Social Security Act to permit four classes of Secretarial waivers:

- Waivers to implement primary care case management systems;
- Waivers to permit localities to act as central brokers in helping Medicaid recipients choose among competing health plans;
- Waivers to allow States to share with recipients savings resulting from the use of more cost effective care; and
- Waivers to restrict recipients to receiving non-emergency care from only efficient and cost-effective providers.

The waivers are granted for a two year period and States may request a continuation.

Additional OBRA legislation modifying Section 1902(3)(2)(B) and Section 1903(m) of the Social Security Act had the intent of encouraging and enabling Medicaid Agencies to make greater use of HMOs to provide cost-effective health care to Medicaid recipients. These regulations permitted State Medicaid Agencies to:

- Contract on a risk basis with HMOs other than those that meet all the requirements for a Federally qualified HMO;
- Raise the limit on the proportion of HMO enrollees that may be persons eligible for Medicare or Medicaid from 50% to 75%; and
- Provide State Medicaid Agencies the option of continuing Medicaid for a period of up to six months from date of enrollment in a Federally qualified HMO, even if the enrollee loses Medicaid eligibility before the end of that period.

This project was initially conceived as a study to examine changes in Medicaid enrollment in HMOs and in barriers to enrollment. Two surveys were proposed: one survey to evaluate the activities of State Medicaid Agencies with alternative HMOs or guaranteed enrollment periods, and one survey to assess the impact of Medicaid waivers on HMO enrollment. As background information was studied several factors were determined that had an effect on how the study was conducted and exactly what was assessed. Those factors were:

- Several Medicaid Agencies had implemented more than one of the new regulations (e.g. Wisconsin has implemented a 2175 waiver, the use of alternative HMOs and the use of guaranteed enrollment periods) and it did not seem appropriate to try to conduct two discrete surveys.

- The dates of implementation of the legislation vary widely across State Medicaid Agencies (MAs) and even within a Medicaid Agency that has implemented more than one of the legislative changes.

- The time elapsed from implementation of the legislation and the data available were not sufficient to determine impact on Medicaid enrollment in HMOs.

Given those considerations, a decision was made to conduct one survey of all three legislative changes of interest. The focus of the study was shifted from assessing impact on Medicaid enrollment in HMOs to describing Medicaid and HMO contracting.

CHAPTER TWO
PURPOSE AND OBJECTIVES

This chapter discusses the need for the study, the study purpose and objectives, and the study use and limitations.

A. NEED FOR THE STUDY

Today, four years after the effective date of the OBRA legislation, there appear to be large incentives for Medicaid/HMO contracting. Enrolling increased numbers of Medicaid enrollees in HMOs could result in reduction of costs to the Federal and State governments. Medicaid Programs must respond to the escalating Medicaid costs and one way to reduce costs is to contract with HMOs. The OBRA legislation has made Medicaid/HMO contracting more flexible yet, at least in the past, there have been other issues involved.

Historically, both HMOs and State Medicaid Agencies have viewed their participation in contracting with some skepticism. Issues of concern have been related to constant changes in recipients' eligibility status, difficulties in marketing, administrative burdens of reporting, stigma of Medicaid enrollees, reimbursement/capitation rates, a "sicker" and costly client group. The bottom line has been whether or not HMOs could profitably serve Medicaid recipients. This study was commissioned by the Health Resources and Services Administration to examine the impact that the OBRA legislation has had on Medicaid/HMO contracting.

B. STUDY PURPOSE AND OBJECTIVES

The purpose of this project has been to assess the impact of specific legislative changes on HMO/Medicaid contracting. The legislative changes to be evaluated for their impact are:

- Section 1915(b) of the Social Security Act (Omnibus Budget Reconciliation Act (OBRA Section 2175) - Waivers of State Plan requirements affecting the freedom of Medicaid enrollees to choose providers of health care services.

- Section 1903(m) of the Social Security Act (OBRA Section 2178) - The expansion of the definition of HMOs eligible to contract with States under the Medicaid Program to include State-qualified HMOs.

- Section 1902(3)(2)(B) of the Social Security Act (OBRA Section 2178) - The guaranteed eligibility provision which provides State Medicaid Agencies the option of continuing Medicaid enrollment for an enrollee for a period of up to six months in a Federally qualified HMO, even if the enrollee loses Medicaid eligibility before the end of that period.

The basic goal of the study is to help State Medicaid Agencies and HMOs improve their contracting relationships, thereby increasing the enrollment of Medicaid recipients in HMOs. The underlying objectives of the study are as follows:

- To describe the basic characteristics of HMO/Medicaid contracting.
- To examine the effect of legislative changes in the relationship between Medicaid Agencies and HMOs.
- To document the processes used by HMOs/State Medicaid Agencies to achieve successful working and contracting arrangements.
- To assess the impact of Medicaid waivers, State-qualified HMOs, and guaranteed enrollment periods on Medicaid enrollment in HMOs.
- To assess the impact of the legislative changes on reducing or eliminating barriers to HMO/State Medicaid Agency contracting.

These objectives are addressed in the analysis in chapters four and five.

C. STUDY USE AND LIMITATIONS

This study was designed to:

- Provide information to the Department of Health and Human Services (DHHS) about the impact of the three major legislative changes on Medicaid/HMO contracting; and
- Provide HMOs and State Medicaid Agencies with information on successful approaches to contracting for HMO health care services to Medicaid enrollees.

The study provides DHHS with information that is useful in making policy decisions and in giving technical assistance to both HMOs and State Medicaid Agencies. It provides HMOs and State Medicaid Agencies with information on contracting activities in other States and show how HMOs and State Medicaid Agencies have solved contracting problems. This information is useful in making policy decisions on a HMO and State Medicaid Agency level.

This study has yielded a large amount of information regarding the current status of HMO/Medicaid contracting. The study was designed to describe basic characteristics, the use of OBRA legislation, contracting processes, and the results of contracting of HMOs and State Medicaid Agencies. Many of the State Medicaid Agencies have not been contracting with HMOs long enough to assess the impact of the contracting process. With the exception of Wisconsin, no State Medicaid Agency has evaluated contracting efforts and results.

While the study was structured so that data could be analyzed according to each OBRA legislative authority used and each combination of OBRA contracting/pre-OBRA contracting/no contracting, none of those factors could, at this time, be considered significant contributors to the success/failure of HMO/Medicaid contracting. Our analysis is consequently focused on State Medicaid Agencies contracting with HMOs vis-a-vis State Medicaid Agencies not contracting with HMOs and State Medicaid Agencies perceptions vis-a-vis HMO perceptions. Although there were common themes, each HMO report and State Medicaid Agency report was unique.

Achieving the goal of examining HMO/Medicaid contracting across States is inherently difficult due to the large number of options in eligibility groups served, benefits provided, methods used to set rates, etc. The process is further complicated by the fact that the implementation date for contracting varies and even of itself is difficult to define. State Medicaid Agencies spend varying lengths of time in the start-up of HMO/Medicaid contracting. Thus it is difficult to establish a benchmark.

The scope of this project was all jurisdictions within the continental United States in which the State Medicaid Agency contracted with HMOs for services for Medicaid enrollees and a sample of State Medicaid Agencies that did not contract with a HMO for services for Medicaid enrollees. Arizona does not currently have a State Medicaid Program and thus was not included in the study. Other States not included were Missouri, New Jersey and Florida which contract with HMOs but under demonstration projects. California, Minnesota, and New York also have demonstration projects but their contracting process was examined for that part that was outside of the demonstration project. Currently an evaluation is being conducted of the demonstration projects and information on these projects is available through other sources.

CHAPTER THREE
SURVEY METHODOLOGY

The methodology used for this study was basically a telephone survey of states and associated HMOs. However, it was necessary to first identify the appropriate respondents by using secondary source documents and a limited number of site visits. Once groups of respondents had been identified, appropriate survey instruments were designed and the information acquisition protocol was developed. Each of the components of the survey methodology is discussed below.

3.1 SELECTION OF SURVEY RESPONDENTS

In order to identify states with HMO contracts and states that have implemented one or more of the legislative provisions, several different activities were undertaken:

- A list of states contracting with HMOs for Medicaid recipients was developed using information from the Office of HMOs and information from HCFA on Medicaid and HMO activity.
- The HCFA representatives in the DHHS Regions were contacted to ascertain state activity in regard to the legislative provisions.
- Knowledgeable individuals within the private sector and the federal government were interviewed.

The information gathered from these activities was structured into a matrix which was then analyzed in terms of groupings. Seven distinct groups were identified: (1) States with a 2175 waiver that contract with HMOs; (2) States with extended eligibility; (3) States that contract with state-qualified HMOs; (4) States with no HMO contracts under the 2175 waiver but which contract with HMOs; (5) States with OBRA legislative authority but no HMO contracts; (6) States with no OBRA legislative authority but which contract with HMOs; and (7) States with no OBRA legislative authority and no HMO contracts. Exhibit 1 displays the states by group. In each of the states identified a survey was conducted at the State Medicaid Agency level and with at least one HMO contractor. The criterion used to select HMOs included a range of sizes, percent of Medicaid populations, and lengths of time contracting with the Medicaid Agencies. In those states to which site visits were made, additional HMOs were interviewed.

3.2 INFORMATION TO BE ACQUIRED FROM STATES AND HMOs

Prior to the development of the interview guides for the survey, site visits were made to four states. Two of the states, Michigan and Wisconsin, were selected bacause of their innovative programs. Two additional states, Maryland and Pennsylvania, were visited on one-day site visits. These four site visits served as a basis of understanding and knowledge from which to develop interview guides. The interview guides, seven each for the Medicaid Agencies and the HMOs, can be found with each group's interview report.

3.3 INFORMATION ACQUISITION PROTOCOL

In advance of the conduct of the telephone survey, a letter was mailed to State Medicaid Directors in those states selected for the study. This correspondence included a one-page synopsis of the project and a return post card for the State Directors to indicate the interview contact person and phone number. upon receiving the returned post card, La Jolla phoned the contact person to set up an interview time and to discuss the HMOs with which the state contracted and select one for the survey. Upon completion of that call, the contact person was mailed a project synopsis and appropriate interview guide. The telephone interviews were then conducted as scheduled. The project staff wrote interview reports, a copy of which was mailed to the interviewee. The interviewee was then telephoned for any change/corrections to this report to complete the verification process. The same methodology was used for the conduct of the HMO interviews. This report is a compilation of those Medicaid Agency and HMO interviews.

The interviews were conducted over the time period of February - June 1985. The status of each state was taken to be that as of September 1984. States have made OBRA changes subsequently and those are noted on the interview forms.

CHAPTER FOUR
STATE-BY-STATE ANALYSIS

1. OVERVIEW

Thirty State Medicaid Agencies and at least one HMO in each of those States were surveyed in terms of seven groupings. The States are divided into two basic groups--those States where the State Medicaid Agency uses OBRA 1981 legislative authority and those States where the State Medicaid Agency does not use OBRA 1981 legislative authority. The twenty States that fall within the category of State Medicaid Agencies having implemented OBRA 1981 legislation are further divided into five groups based on the specific legislation the Medicaid Agency implemented and how the Medicaid Agency incorporated this legislation into HMO contracting. Ten States had Medicaid Agencies that did not implement OBRA 1981 legislative authority and were grouped according to whether the Medicaid Agency contracted with HMOs for the Medicaid population. The groupings with the State Medicaid Agencies and HMOs are as follows:

GROUP ONE: States with a 2175 waiver that have HMO/Medicaid contracts.

This group has implemented Section 1915(b) of the Social Security Act (OBRA Section 2175 waiver). This is a waiver of State Plan requirements affecting the freedom of Medicaid enrollees to choose providers of health care services.

Three States have HMOs that contract with Medicaid Agencies and incorporate the Section 2175 waiver in their contracting. These States have a total of sixteen HMO contracts and the HMOs serve a total of 4% of the Medicaid population. Two State Medicaid Agencies have voluntary enrollment and one has forced enrollment. Two of the State Medicaid Agencies also make use of other OBRA 1981 legislative authority--both New York's and Wisconsin's Medicaid Agencies contract with State-qualified HMOs and Wisconsin's Medicaid Agency provides extended eligibility for one month. The HMOs in New York and Utah serve the majority of the eligibility groups while in Wisconsin only the AFDC population is served by the HMOs. HMO/Medicaid contracting began in New York in 1978, in Utah in 1977, and in Wisconsin in 1982.

MEDICAID AGENCY	HMO
New York	*
Utah	FHP, Utah
Wisconsin	HealthPlus
	Samaritan Health Plan
	TotalCare Health Plan, Inc.

*New York has two small HMO/Medicaid contracts with a total of 50 enrollees and the remainder of the capitated plans are PHPs. The New York Medicaid Agency requested that the HMOs not be contacted.

GROUP TWO: State Medicaid Agencies with extended eligibility.

This group has implemented Section 1902(3)(2)(B) of the Social Security Act (OBRA Section 2178) which is the six month guaranteed eligibility provision. State Medicaid Agencies with this provision provide benefits for categorically and/or medically needy recipients who are enrolled in a Federally-qualified HMO (under a risk contract) and who become ineligible for Medicaid, for a period of up to six months.

Five State Medicaid Agencies have the extended eligibility provision. This group has 8.2% of the Medicaid population enrolled in HMOs and has a total of twenty-five HMO contracts. Four of the State Medicaid Agencies have voluntary enrollment and one State has forced enrollment. Four States have HMO/Medicaid contracts that serve the AFDC Medicaid eligibility group while one HMO/Medicaid contract serves the AFDC, foster care and child welfare services eligibility groups. HMO contracting in this group began in 1977, but the majority of the HMO/Medicaid contracting began in 1983 and 1984. Two of the State Medicaid Agencies also make use of other OBRA legislative authorities--Minnesota's and Wisconsin's Medicaid Agencies contract with State-qualified HMOs and Wisconsin's Medicaid Agency has the 2175 waiver.

MEDICAID AGENCY	HMO
Connecticut	**
Indiana	MetroHealth Plan
Minnesota	Group Health, Inc.
New Hampshire	Matthew Thornton Health Plan
Wisconsin	See above in Group One

**Connecticut's only HMO with a Medicaid contract was non-responsive.

GROUP THREE: States having State-qualified HMOs contracting with State Medicaid Agencies.

This group has implemented Section 1903(m) of the Social Security Act (OBRA Section 2178) which expands the definition of HMOs eligible to contract with States under the Medicaid program to include alternative HMOs. In other words, State Medicaid Agencies with this provision can now have contracts with HMOs that meet the State definition of an HMO and still qualify for FFP as a result of this OBRA 1981 legislation. The State-qualified HMOs must furnish comprehensive services under a risk contract and must: (1) Make provisions (satisfactory to the State Medicaid Agency) against the risk of insolvency and assure that Medicaid recipients will not be responsible for the HMO's debts if it does become bankrupt; and (2) Make their services available to Medicaid enrollees to the same extent they are available from other sources to nonenrolled Medicaid recipients in the area. The State Medicaid Agency may impose additional requirements it finds necessary, however no State Medicaid Agency reported imposing any additional requirements.

Nine of the State Medicaid Agencies contracted with State-qualified HMOs. This group has a total of 56 contracts and has 4.3% of the Medicaid population enrolled in HMOs. Most of the nine State Medicaid Agencies contracted with Federally qualified as well as State-qualified HMOs. Eight of the State Medicaid Agencies have voluntary enrollment while Wisconsin's Medicaid Agency has forced choice enrollment. Five States have HMO/Medicaid contracts that serve the AFDC Medicaid eligibility group only, California and New York have HMO/Medicaid contracts serving the AFDC and SSI, Massachusetts HMO/Medicaid contracts serve the AFDC, SSI and refugee eligibility groups and Maryland's HMO/Medicaid contracts serve all Medicaid eligibility groups. HMO/Medicaid contracting in this group began in the early 1970s. Three State Medicaid Agencies also make use of other OBRA legislative authority. New York's and Wisconsin's Medicaid Agencies have the 2175 waiver, and Minnesota's and Wisconsin's Medicid Agencies provide extended eligibility.

MEDICAID AGENCY	HMO
California	CIGNA Health Plan of Southern California Kaiser Permanente of Southern California Watts Health Foundation
Illinois	Chicago HMO
Maine	Franklin Area Health Plan
Maryland	Carefirst/Metropolitan Baltimore Health Plan, Inc.
Massachusetts	Harvard Community Health Plan
Minnesota	See above in Group Two
New York	See above in Group One
Ohio	HealthAmerica of Ohio
Wisconsin	See above in Group One

GROUP FOUR: States with no HMO/Medicaid contracts under the 2175 waiver but have HMO/Medicaid contracts.

This group has implemented the OBRA Section 2175 waiver affecting the freedom of choice of Medicaid enrollees to choose health care providers but the Medicaid Agencies do not incorporate the use of the Section 2175 waiver in HMO contracting.

Three State Medicaid Agencies have the Section 2175 authority and contract with HMOs but do not use the authority in the Medicaid/HMO contracts. These State Medicaid Agencies have a total of thirteen contracts and have 7.4% of the Medicaid population enrolled in HMOs. Washington's HMO/Medicaid contracts serve the AFDC Medicaid eligibility group while the other two States HMO/Medicaid contracts serve all Medicaid eligibility groups. All State Medicaid Agencies have voluntary enrollment. HMO/Medicaid contracting began in the 1960s in Washington and in the 1970s in Colorado and Michigan.

MEDICAID AGENCY	HMO
Colorado	Rocky Mountain HMO
Michigan	Comprehensive Health Services
	Group Health Plan of Southeast Michigan
	Michigan HMO Plans, Inc.
Washington	Kaiser Permanente of the Northwest
	Group Health of Puget Sound
	Group Health of Spokane

GROUP FIVE: State Medicaid Agencies with OBRA legislative authority but no HMO/Medicaid contracts.

This group has also implemented the OBRA Section 2175 waiver affecting the freedom of Medicaid enrollees to choose providers of health care services but does not have any HMO/Medicaid contracts under the waiver or otherwise. Four State Medicaid Agencies in our sample have the legislative authority but did not contract with HMOs. One HMO in each of the four States was interviewed to determine why they do not contract with the State Medicaid Agency and if they have any current and/or future plans to contract with the Medicaid Agency. The four interviewed HMOs that do not contract with the State Medicaid Agency are listed below.

MEDICAID AGENCY	HMO
Kansas	Family Health Plan, Inc.
Kentucky	Mountain Trails Health Plan
Nevada	Health Plan of Nevada-Ltd.
Tennessee	PRUCARE of Nashville

GROUP SIX: State Medicaid Agencies with no OBRA legislative authority but have HMO contracts.

This group has not implemented OBRA 1981 legislation but does have Medicaid/HMO contracts. Four States fit into this category of having HMO/Medicaid contracts without the use of OBRA 1981 legislation.

This group has a total of six HMO contracts and the HMOs serve 1.3% of the Medicaid population. Three of the State Medicaid Agencies have voluntary enrollment while Oregon's Medicaid Agency has forced choice enrollment. Oregon's and the District of Columbia's Medicaid Agencies contract with HMOs to serve the AFDC Medicaid eligibility group, Rhode Island's Medicaid Agency contracts for the AFDC, medically needy and foster children eligibility groups; and Pennsylvania's Medicaid Agency contracts with all Medicaid eligibility groups. All the HMO/Medicaid contracts began in the 1970s.

MEDICAID AGENCY	HMO
District of Columbia	Kaiser Foundation of the Mid-Atlantic States, Inc.
Oregon	Kaiser Permanente of the Northwest
Pennsylvania	Philadelphia Health Plan
Rhode Island	Rhode Island Group Health Association

GROUP SEVEN: State Medicaid Agencies with no OBRA legislative authority and no HMO contracts.

This group has not implemented OBRA 1981 legislation and does not have any HMO/Medicaid contracts. Six of the State Medicaid Agencies did not have OBRA legislation and also did not have HMO/Medicaid contracts. One HMO in each of the six States was interviewed to determine if they had any current and/or future plans for Medicaid contracting as well as their main reasons for not contracting with the State Medicaid Agency at the present time. The six State Medicaid Agencies as well as the interviewed HMOs that do not contract with the Medicaid Agency are listed below.

MEDICAID AGENCY	HMO
Georgia	Health 1st, Inc.
Iowa	Medical Association HMO
North Carolina	Winston Salem Health Care Plan
Oklahoma	Pru Care of Oklahoma
Texas	Planned Health, Inc.
Virginia	Network Health Plan

B. STATE PROFILES

The following section alphabetically presents information collected in interviews with 30 State Medicaid Agencies and at least one HMO in each of those States.

CALIFORNIA

- State contracts with state-qualified HMOs
- Twelve HMO contracts
- Contracting with HMOs since the early 1970's
- Serve the AFDC, AB, OAS, and the ATD Medicaid eligibility groups
- 5.8% of Medicaid population enrolled in HMOs
- Voluntary enrollment
- 8 federally-qualified HMOs, 4 state-qualified HMOs

California contracts with HMOs that meet the State defininition of a HMO and qualify for FFP as a result of OBRA 1981 legislation.

California felt that the Medicaid/HMO contracting began in the early 1970s out of the State's effort to save money and to contract health care delivery to the private sector. One interviewed HMO stated that the impetus to contracting was the passage of two acts: the Waxman-Duffy Act in 1972, and the Knox-Keene Act in 1975. The three interviewed HMOs all cited various reasons for their current contracts with Medicaid. One stated that it is a cost-effective means to provide health care to Medicaid eligibles, another felt a committment to provide this health care, while another serves almost two-thirds Medicaid clients in their HMO so it is practical for them to contract.

The State and the HMOs cite a few problems with Medicaid/HMO contracting. Both see a problem with the reimbursement rate as most HMOs are taking quite a cut on the Medicaid side. There is also a problem with the timeliness of the rate increases and adjustments and the payment. Both parties see marketing as a problem, especially the HMOs since they see marketing as expensive (some do door-to-door marketing) and their marketing opportunity as limited (the county office often has the sole responsibility). The HMOs all cited eligibility determination as a problem because of the turnover and the frequent difficulties on verifying eligibility. The State also said that the 75% rule is not a major problem but a few HMOs have had to apply for waivers in order to meet this rule.

The HMOs felt that one of the major reasons for their current Medicaid enrollment was the State's dual choice program. Other factors were their sound reputation, their committment to this population and their marketing approach.

Enrollment has gone up steadily during the years. In 1984, the number of Medicaid enrollees in HMOs was 198,379. The State is currently saving money with this program but sees the saving margins between FFS and HMOs decreasing.

COLORADO

- State has 2175 waiver but does not incorporate the waivier in HMO contracting
- Three HMO contracts
- Contracting with HMOs since 1974
- Serve all Medicaid eligibility groups
- 3.6% of Medicaid population enrolled in HMO
- Voluntary enrollment
- All HMOs are federally-qualified

Colorado has implemented a 2175 waiver but does not incorporate the waiver in Medicaid/HMO contracting. Colorado has a case management system waiver which became effective August 2, 1982 (revised effective date May 1, 1983), called the Primary Care Provider Program (PCPP). However, the HMOs that contract under this program do not operate under the 2175 waiver. Colorado would like to use the freedom of choice waiver and only offer the HMO option to Medicaid eligibles sometime in the future.

The interviewed HMO was the impetus to Colorado's Medicaid/HMO contracting. They approached the State about contracting who then agreed to contract. The contracting also has physician support because they felt the HMO could negotiate a good position for them. The primary reason that the interviewed HMO continues to contract is because the physicians feel that it is a better financial mechanism for them.

The Colorado State Medicaid Agency perceives a few barriers to contracting. There are some eligibility processing problems as there is no on-line system and if the forms are not processed by the 20th of the month, then the enrollees do not get on the HMO rolls. Also, edits can not be done on their information system which causes adjustment problems. The major barriers or problems that the interviewed HMO cited were with eligibility determination and marketing because they have a problem getting information from the State on who is eligible and also getting accurate information on the eligibles.

The HMO cites two major reasons leading to the current status of their Medicaid enrollment. First, they have 85% of the area physicians in the plan and they endorse this product to their patients and encourage the Medicaid population to get into the HMO. Also, there has been a significant amount of support over the years from the County Social Services Department for the HMO.

The State is currently conducting a study on enrollment. They are not satisfied with the present enrollment (5,580 in 1984) and are trying to increase it. Cost savings from HMO contracting have been achieved as they negotiate rates at 95% of the FFS.

CONNECTICUT

- State provides extended eligiblity for 6 months
- One HMO contract
- Contracting with HMO since 1983
- Serve the AFDC Medicaid eligibility group
- .1% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is federally-qualified

Connecticut provides benefits for the AFDC Medicaid eligible recipients who are enrolled in a federally-qualified HMO and who become ineligible for Medicaid, for a period of 6 months.

A State initiative was the impetus to Medicaid/HMO contracting. In January 1980, the State began to approach several HMOs about contracting and one of the State's largest and most fiscally sound HMO agreed to contract. This contracting HMO, however, did not wish to participate in the survey.

The State cites a few problems with Medicaid/HMO contracting. First, they feel that federal requirements are a problem for their one contracting HMO as well as other interested HMOs. Secondly, they feel that the perception of Medicaid recipients as high medical utilizers and troublesome clients prevents HMOs from establishing a Medicaid contract. Also, the State feels that competition with Medicare contracts has proved to be a Medicaid/HMO barrier. One reason for this is because many HMOs are concentrating their efforts on current Medicare contracts and are not interested in establishing a Medicaid/HMO contract at the present time.

There has been a steady increase in HMO enrollment in Connecticut from 229 in 1983 to 391 in 1985. Most disenrollment is caused by loss of eligibility or a change in eligibility. The State said that the extended eligibility provision has resulted in cost increases as there was a $1,700 additional cost through April 1984. The State is, however, still experiencing a cost savings of about 5%.

DISTRICT OF COLUMBIA

- No OBRA legislative authority but contract with HMOs
- One HMO contract
- Contracting with HMO since 1972
- Serve the AFDC Medicaid eligibility group
- .1% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is federally-qualified

The District of Columbia had no OBRA legislative authority as of September 1984, this study's cut-off date, but did engage in Medicaid/HMO contracting. However, DC now provides benefits for categorically needy and medically needy recipients who are enrolled in a federally qualified HMO and who become ineligible for Medicaid, for a period of 6 months.

D.C. stated that they had found Medicaid/HMO contracting to be cost-effective from a demonstration project which then led them to contract with a HMO. The contracting HMO stated that they began contracting with D.C. because Medicaid was a source of membership and also fulfilled their committment to provide health care to the community. This committment is the reason why the HMO continues to contract with D.C. today.

The D.C. Medicaid Agency found no problems with Medicaid/HMO contracting. The major problem or barrier to contracting that the HMO found was in payment but is optimistic that a new payment system negotiated for the future will resolve past problems. The HMO has also experienced an administrative burden since the payment problem has been time-consuming to resolve.

The HMO cites a few factors that lead to the current status of the Medicaid enrollment. First, they are committed to having Medicaid in their HMO population and they see contracting as a community service. Secondly, they view the program as a source of enrollment for them as well as helping D.C. contain costs.

Enrollment has fluctuated somewhat over the years but has always been relatively low. Enrollment in 1985 is 150. In terms of cost savings, no studies have been done, but they do know that cost savings have been achieved. The monthly fee is about $71 and fee-for-service is over $100.

GEORGIA

- State has no OBRA 1981 legislative authority
- No HMO contracts

Georgia does not have OBRA 1981 legislative authority and has no current contracts with any HMOs. The Georgia State Medicaid Agency is currently looking into contracting with HMOs. They have sent out letters of inquiry to HMOs that have indicated an interest in contracting. Five federally-qualified HMOs have expressed an interest in contracting and the State is in the process of establishing contracts.

Georgia's reasons for not contracting with HMOs to date is that the HMOs had not expressed any interest in contracting and the State has had some difficulty with their utilization data and they did not want to contract without this data. About one year ago, they got county specific utilization data, so the State became more interested in contracting since they could offer the HMOs data.

The interviewed HMO's reasons for not contracting with the State Medicaid Agency is that they had been concentrating their efforts on their private sector clients and their Medicare contract. They are considering the possibilities of contracting and are making preparations to contract for the Medicaid population.

ILLINOIS

- State contracts with state-qualified HMOs
- Six HMO contracts
- Contracting with HMOs since 1976
- Serve the AFDC Medicaid eligibility group
- 4.4% of Medicaid population enrolled in HMO
- Voluntary enrollment
- 3 federally-qualified HMOs, 3 state-qualified HMOs

Illinois contracts with three HMOs that meet the State definition of a HMO and qualify for FFP as a result of OBRA 1981 legislation. The three contracts with the state-qualified HMOs began in 1984.

The State has had contracting with HMOs since 1976, but the major impetus to Medicaid/HMO contracting came in 1982 when Governor Thompson held a Medicaid conference to review the structure of the Medicaid system and, at this time, Medicaid/HMO contracting was encouraged. The interviewed HMO stated that they went to the State in the late 1970s to start a contract because they felt a Medicaid/HMO contract was necessary in order to protect their enrollment base.

The State Medicaid Agency perceived no major barriers or problems with their Medicaid/HMO contracts. The interviewed HMO, however, mentioned a few barriers with their contract. First, they felt the turnover of their Medicaid population to be a problem since the State has no extended eligibility or lock-in provision. They also cited problems with contracting and the rate structure because of instability in money due to the legislative process that effects the negotiation process. The HMO also stated that their Medicaid population is a difficult population to manage because they do not have a rudimentary knowledge about health and because about one-third to one-half of their Medicaid clients are illiterate.

One of the major factors leading to this HMO's current Medicaid enrollment is that they feel they started with an inner city committment and that they still have this committment. They have carved a unique niche in the HMO market as they appeal to the blue collar and inner city individual. This HMO stated that the one factor that would help their enrollment would be to enroll their Medicaid population the way they enroll their private population--they would like open enrollment once a year, and when you join, you stay in the program for 12 months.

Enrollment of the Medicaid population in HMOs has been growing over the years--from 1,464 in 1976 to 56,114 in 1984. The biggest increase took place between 1982 and 1983 when the enrollment went from 6,589 to 35,375. Illinois also stated that they are now experiencing a cost savings with this Medicaid/HMO program since the reimbursement rate is determined by 85% of FFS.

INDIANA

- State provides extended eligibility for 3 months
- Two HMO contracts
- Contracting with HMOs since 1983
- Serve the AFDC Medicaid eligibility group
- 1.1% of Medicaid population enrolled in HMOs
- Voluntary enrollment
- HMOs are federally-qualified

Indiana provides benefits for the AFDC Medicaid eligible recipients who are enrolled in a federally-qualified HMO and who become ineligible for Medicaid, for a period of three months.

Medicaid/HMO contracting began when the State Health Department agreed to contract with a HMO that had been interested in establishing a Medicaid contract for about eight years. The interviewed HMO stated that they still contract with the State because they feel a committment to serving a cross-section of the population which includes Medicaid.

Both the State and the interviewed HMO cited turnover of the Medicaid eligibles as a barrier/problem in contracting. From 1983 to 1984, the enrollment dropped from 4,179 to 3,021. The HMO feels that this problem is connected to their marketing and enrollment approach. This HMO's enrollment office is not located within the County Welfare Office, so the interested eligible must go over to the HMO office if they wish to enroll. Another barrier that the HMO mentioned was that the State only allots one Medicaid card per family and there is no place on the card to show which members are on the HMO plan and which are on the State plan. This causes a problem at the site where services are rendered because it is difficult to determine who is eligible for the HMO.

The HMO felt that their marketing access problem was the major factor leading to their current Medicaid enrollment. They felt it could be higher if not for this problem. Also, Indiana has a very rich benefits package which is hard for the HMOs as it does not give the Medicaid recipients any incentive to join the HMO.

Enrollment has decreased in one HMO and there is no Medicaid enrollment to date in the other contracting HMO. No studies have been done on cost savings but the HMOs are given 95% of the fee-for-service rate.

IOWA

- State has no OBRA 1981 legislative authority
- No HMO contracts

Iowa does not have OBRA 1981 legislative authority and has no current contracts with any HMOs. The Iowa State Medicaid Agency, however, does anticipate future contracts with HMOs. They have just recently hired staff to investigate the possibilities of HMO contracting and the State has January 1987 as the future goal to implement a Medicaid/HMO contract.

Iowas's reasons for not contracting to date are that Medicaid/HMO contracting had not been a top priority in the past since they were concentrating their efforts on hospital capitation and other issues. They are now, however, interested in the possibilities of contracting. Also, there are only about five HMOs in the State, two which are very new, and they are all located primarily in the eastern part of the State where there is a low Medicaid population. This is another reason that did not lead them to think much about HMO contracting in the past.

The interviewed HMO in Iowa stated that they have not contracted with Medicaid because they are a relatively new HMO and have been concentrating their efforts on the basic market populations. They are also relatively unfamiliar with the Medicaid population which is another reason why they have not thought seriously about Medicaid/HMO contracting. They stated that they would consider contracting if the State approached them about establishing a contract.

KANSAS

- State with 2175 waiver
- No HMO contracts

Kansas has a freedom of choice waiver under 1915(b) of the Social Security Act. They use it now in their primary care network (PCN). In their PCN, a managment fee (a nominal fee of approximately $3) is paid monthly to the physician for case management. In addition, the physician is paid fee-for-serice for any services rendered. Enrollees must go to a PCN but are given a choice of physicians within the primary care network.

Kansas does not hve any contracts with HMOs at this time but has had one HMO approach them for contracting. This HMO had proposed a contract but all items stated in the contract were not acceptable to the State. Kansas does have plans to contract in the future if an acceptable contract could be negotiated with a HMO.

An interviewed HMO in Kansas stated that they plan to enter into a contract with the State Medicaid Agency in a few months on an experimental project. If the project is successful, the State may consider a Medicaid/HMO contract with this HMO. If they did contract with Medicaid, this HMO stated that they are unsure if they would like to see the freedom-of-choice waiver incorporated into their contracting.

KENTUCKY

- State with 2175 waiver
- No HMO contracts

Kentucky has two 2175 waivers, one which is currently effective. A waiver to provide inpatient acute care hospital services through a preferred provider arrangement to individuals in Fayette County was implemented January 1, 1984. The State also had a 2175 waiver for case management, sharing of cost savings, and restricting providers which was effective November 10, 1982. This authority enabled Kentucky to implement a Health Insuring Organization (HIO) called Citicare. The Citicare contract was cancelled in 1984.

Kentucky does not contract with any HMOs. Kentucky stated that they have run into problems with HMO contracting because the HMOs want: fee-for-service rates (versus a capitated rate), guaranteed enrollment, and not to serve the aged, blind and disabled Medicaid eligibility group. Because of these conflicts, Kentucky is not contracting with HMOs at the present time. The State also feels that if the system for mandatory statewide case management is instituted for private physicians and clinics, they do not see much of a chance for future Medicaid/HMO contracting.

The interviewed HMO in Kentucky stated that they had met with the State Medicaid Agency during the last administration to discuss the possibilities of contracting but not with the new administration because they feel the new administration is not willing to work out a contract with any HMOs at this time.

MAINE

- State contracts with State-qualified HMOs
- One HMO contract
- Contracting with HMO since 1984
- Serve the AFDC Medicaid eligibility group
- .36% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is state-qualified

Maine contracts with an HMO that meets the State definition of a HMO and qualifies for FFP as a result of OBRA 1981 legislation. It was the OBRA 1981 legislation that permitted the HMO to contract with Medicaid.

Contracting in the State began when the HMO became interested in contracting and approached the State with the idea. The Department of Human Services Director and the Executive Director of the HMO then got together and decided it was in both their best interests to contract. The HMO stated that they continue their current contract with Medicaid because they feel they have a committment to serve this population.

The major barrier that the State has with contracting is that the State-qualified HMO is not familiar with reporting requirements and they think it would be easier to contract with a federally-qualified HMO, however, there are none in the State of Maine. The HMO also sees a few barriers to contracting. Marketing for the HMO is a problem because it is such a time consuming task to find the eligibles and enroll them. They have also experienced problems with eligibility determination as they often have not known who is on or off the eligible list. The HMO also stated that they spend about 45% of their administrative time on their 10% Medicaid enrollment primarily because the HMO sends in their billing to the State in zip code format and the State sends back the data on an alphabetical list.

The HMO feels that one of the major factors leading to their current Medicaid enrollment is that their providers get a better deal in the Medicaid/HMO contract than they would under the regular Medicaid system.

There have been no results seen in terms of enrollment or cost savings in the Medicaid/HMO contracting as the program has been in operation for only one year. The current Medicaid enrollment in the HMO is 444.

MARYLAND

- State contracts with state-qualified HMOs
- Five HMO contracts
- Contracting with HMOs since 1975
- Serve all Medicaid eligibility groups
- 4.5% of Medicaid population enrolled in HMO
- Voluntary enrollment
- 1 federally-qualified HMO, 2 state-qualified HMOs, and 2 HMOs grandfathered in as a result of an grant under the Public Health Services Act.

Maryland contracts with HMOs that meet the State definition of a HMO and qualify for FFP as a result of OBRA 1981 legislation. Also, three of the HMO's that Maryland contracts with are capitation plans that are considered as both prepaid health plans (PHPs) and as HMOs because the State has a broad definition of HMOs. In addition, the Office of Health Maintenance Organizations considers these plans as HMOs but the federal Medicaid office considers these plans as PHPs.

The State was the major impetus to Medicaid/HMO contracting as they approached the HMOs about contracting. The interviewed HMO stated that they started to contract because they wanted to foster a good relationship with the State as well as desired to serve all segments of the population. The HMO's current reasons for contracting are that they have a desire to serve all segments of the population which includes this Medicaid population and they recognize that there is a need to provide quality care to this group of people and they feel a committment to provide this service.

The State feels that there are no major barriers to contracting. They stated that the HMOs do have some problems with the capitation rate that is set by the State but they do not see this as a major problem in contracting. The only problem that the interviewed HMO cited with their Medicaid contract was with marketing. They have a problem getting the Medicaid eligibles to consider the HMO option and give up their Medicaid card for the HMO card because they associate the Medicaid card with "carte blanche" care and the HMO card with restrictive care. The eligibles are unsure of the HMO delivery system and it is difficult to make them aware of the benefits of the HMO option.

The HMO feels that the major factor leading to their current Medicaid enrollment is that the HMO is conveniently located to this segment of the population and that they offer quality services as well as comprehensive health services.

In terms of results of the Medicaid/HMO contracting, enrollment of the Medicaid population in the HMOs was decreasing until FY 1984, (from 29,375 in 1976 to 14,575 in 1984). However, as of FY 1985, enrollment has increased to 15,106. Cost savings have been achieved since rates are set at 92.5% of the FFS rate.

MASSACHUSETTS

- State contracts with state-qualified HMOs
- Six HMO contracts
- Contracting with HMOs since 1971
- Serve the AFDC, elderly, disabled and refugee Medicaid eligibility groups
- .74% of Medicaid population enrolled in HMO
- Voluntary enrollment
- 4 federally-qualified HMOs, 2 state-qualified HMOs

Massachusetts contracts with two HMOs that meet the State definition of a HMO and qualify for FFP as a result of OBRA 1981 legislation. Also, in April 1985, the State planned to offer to the categorically needy recipients who are enrolled in federally-qualified HMOs, a six month extended eligibility provision.

The State feels that the impetus to contracting began in the early 1970s when the governor and the Welfare Department felt that adding Medicaid recipients to HMOs would be good for Medicaid recipients as well as for the general population. The agency then started to make overtures toward the HMOs to start some contracts. The interviewed HMO stated that their impetus to contracting began when their board of directors approached the State about the possibilities of contracting.

The State felt that their major barrier to Medicaid/HMO contracting is the stigma associated with serving Medicaid eligibles. They said that the HMOs are concerned about their image, and worry that if they serve the Medicaid population they will be known as the "poor people's clinic." HMOs also feel that Medicaid enrollees are sicker than the rest of the population and that providing care to this population will not be cost effective. In addition, the State said that most of the HMOs are located in middle-class areas making it difficult for Medicaid enrollees to gain access. The interviewed HMO stated that one of their problems with the Medicaid contract is marketing. There is no incentive to join the HMO since the State FFS benefit package is so comprehensive and the HMO benefit package can not offer any additional services. This HMO also has a problem with eligibility determination because they do not always know when the recipients are actually eligible for their services.

The major factor leading to the HMO's current Medicaid enrollment status is their strong committment to Medicaid contracting. They also felt that the six month extended eligibility that was to be implemented in April 1985 would also help increase their Medicaid enrollment.

Medicaid enrollment in the HMOs has been increasing--it was 4,293 in 1985. The State also estimates that they are saving about $16 per enrollee, per month. Therefore, there is approximatley a 7-30% savings depending on the contract and the year.

MICHIGAN

- State has 2175 waiver but does not incorporate the waiver in HMO contracting
- Seven HMO contracts
- Contracting with HMOs since 1972
- Serve all Medicaid eligibility groups
- 8% of Medicaid population enrolled in HMOs
- Voluntary enrollment
- All HMOs are federally-qualified

Michigan has implemented a 2175 waiver but none of the HMOs that Michigan contracts with operate under the waiver.

The Michigan Department of Social Services (MDSS) stated that they have actively sought contracts with HMOs in Michigan since 1972. The three interviewed HMOs had various reasons for establishing contracts--one saw it as a good opportunity to work with the State, another because the community board wanted them to contract, and another felt a committment to serve this population. All the HMOs stated that their current reasons for contracting with Medicaid is their committment in serving this segment of the population.

MDSS did not perceive any major barriers or problems with their Medicaid/HMO contracting. However, the HMOs did perceive some problems or barriers in contracting. All of the HMOs cited turnover of the Medicaid enrollees as a problem. In general, it seems that their turnover or loss of members is primarily due to loss of eligibility or that they want to return to their own private physisican. Two HMOs cited marketing as a problem because it was expensive due to door-to-door marketing and because they have a lack of access to enrollees. One HMO has a problem with the 75% rule and recently opened two new sites to meet the enrollment mix. Another problem that all the HMOs cited is the presence of two prepaid programs in Michigan--the Primary Physician Sponsor Program (PPSP) and Capitated Ambulatory Plan (CAP) or Clinic Plan. The HMOs feel that these plans have received alot of additional publicity and State support which has taken potential members away from the HMOs.

The three interviewed HMOs cited different factors that led to their current Medicaid enrollment. One HMO stated that being an established HMO and offering quality services and health centers has been their major factor. The second HMO has an enrollment base of about 20,000 and stated without this they would not be interested in contracting. The third HMO stated that the PPSP and CAP programs are a major factor in their Medicaid enrollment because, but for the existence of these plans, they would have more enrollees.

HMO enrollment has increased 31% between October 1982 and October 1984 (92,181 in 1984). Cost savings have also been achieved since the rates are based at approximately 90% of the FFS rate.

MINNESOTA

- State provides extended eligibility for 6 months
- State contracts with state-qualified HMOs
- Eight HMO contracts
- Contracting with HMOs since 1977
- Serve the AFDC Medicaid eligibility group
- 1.7% of Medicaid population is enrolled in HMO
- Voluntary enrollment
- 5 federally-qualified HMOs, 3 State-qualified HMOs

Minnesota provides benefits for the AFDC Medicaid eligible recipients who are enrolled in a federally-qualified HMO and who become ineligible for Medicaid, for a period of 6 months. This provision, however, will be stopped as of July 1, 1985 as the State experienced too many problems with this provision.

The State also contracts with HMOs that meet the State definition of an HMO and qualify for FFP as a result of OBRA 1981 legislation.

The State Medicaid Agency was the major impetus in contracting as they approached the HMOs and discussed the possibilities of contracting with them. The interviewed HMO stated that their current reason for contracting with the State Medicaid Agency is that they feel they have a committment to serve the Medicaid population.

The State does not see any barriers/problems to their HMO contracting. However, the HMO stated they had encountered several barriers/problems to contracting. First, they felt their reporting requirements to be onerous as they have to manually abstract the data for the State which then places a great administrative burden on them. Secondly, their contract development process has gone from a very informal process to a very rigid one leading to a more time-consuming process. Marketing has also been a problem for this HMO as marketing the HMO option in one county was discontinued due to pressures from the county medical society. The HMO also mentioned the rate and payment stucture as other problems in the Medicaid/HMO contracting.

The HMO felt that one of the major factors leading to their current Medicaid enrollment was the extended eligibility provision. They also felt that the Medicaid eligibles like the HMO plan as it gives anominity to the Medicaid individual when they receive their HMO card since the card does not state that they are a Medicaid recipient.

Enrollment in the HMOs has been increasing, from 225 in 1982 to 6,600 in 1985. Enrollment may become mandatory as of July 1, 1985. Contracting in the State has not yet been found to be cost-effective.

NEVADA

- State with 2175 waiver
- No HMO contracts

Nevada has a 2175 waiver that is specific to one provider--a medical school. Nevada did consider using the waiver as a vehicle to contract with HMOs, but felt that the requirements to meet the waiver (i.e. reporting) were too great.

The Nevada State Medicaid Agency does not currently contract with any HMOs primarily because the only HMOs in Nevada are in Reno and Las Vegas. Nevada would like to work out contracting with HMOs in the future after they get their case management program running smoothly. However, they would choose to have a straight contract with the HMO rather than under the waiver due to the administrative requirements of the waiver.

The interviewed HMO in Nevada stated that they have not considered the possibilities of contracting with Medicaid because they have recently started contracting with Medicare and are involved with this program. They realize that the Medicaid population is a potential market for them so they do forsee looking into the possibilities of contracting in 1986.

NEW HAMPSHIRE

- State provides extended eligibility for 3 months
- One HMO contract
- Contracting with HMO since 1983
- Serve the AFDC, foster care and child welfare service Medicaid eligibility groups
- 1.3% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is federally-qualified

New Hampshire provides benefits for the categorically needy recipients who are enrolled in a federally-qualified HMO and who become ineligible for Medicaid, for a period of 3 months.

The State Medicaid Agency approached the HMO with the possibility of contracting as it was becoming a popular national idea. The HMO decided to contract with the State as they wanted to establish a good relationship with the State as well as fullfill their committment to serving the poor.

The State Medicaid Agency has experienced no major problems or barriers to contracting. The HMO stated that the only problem encountered in their Medicaid contract was the turnover of Medicaid eligibles. This has been a problem because of tightened certification and recertification procedures as well as changes in Federal eligibility policies.

The HMO stated that one of the major factors leading to their current Medicaid enrollment is that they have retained 30% of the eligibles that were enrolled from the beginning of the contract. They are getting those enrollees that really do want to be members since their HMO enrollment is voluntary. Another factor that the HMO mentioned was that there has been a very consistent approach on the part of the State and the HMO to enrollment.

Enrollment appears to have stabilized over the years at approximately 500 Medicaid clients. New Hampshire has experienced approximately a 30% savings for the years 1983 and 1984.

NEW YORK

- Has 2175 waiver and uses waiver in HMO contracting
- State contracts with State-qualified HMOs
- Two HMO contracts
- Serve the AFDC, SSI, Home Relief Medicaid eligibility groups
- .002% of Medicaid population enrolled in HMOs
- Voluntary enrollment
- Both HMOs are state-qualified

New York was required to apply for a Section 2175 waiver as to establish a 6 month lock-in period for recipients who voluntarily enrolled in prepaid plans. However, it was later determined that such a waiver was not necessary since the majority of the State's enrollees were enrolled in PHPs. This waiver has since terminated. The State is now finding, that as they expand their contracting with other types of HMOs, the inability to secure another such a waiver under Section 2175 is a problem. Also, the State is in the process of applying for an extended eligibility provision as they feel that the inability to provide guaranteed eligibility for enrollees of any type of prepaid capitation plan is a disincentive for both providers and recipients.

New York stated that they have two major health capitation plans. They are listed by the Office of Health Maintenance Organizations as HMOs, but are considered by the State to be prepaid health plans (PHPs). The State also has two small Medicaid/HMO contracts that have a total of fifty Medicaid recipients being served. These HMOs were not interviewed at the request of the State Medicaid Agency.

The State said that the impetus to Medicaid/HMO contracting came in two cycles. The first cycle was the 1976 State legislation that permitted State certification. The second cycle was a reaction to the Reconciliation Act. It was at this time that the State started to think about expanding HMOs and other prepaid capitation contracting, but on a voluntary basis.

New York perceives several barriers to Medicaid/prepaid contracting. The federal government's prohibitions, the 75% rule and the use of guaranteed eligibility are all barriers. Also, since N.Y. has such liberal benefits, clients perceive that they may be losing something by joining an HMO.

Enrollment in the HMOs totaled about 50 Medicaid recipients in 1985 and the number of Medicaid eligibles being served in the PHPs is about 35,000. In terms of savings, the State feels positive about the savings which will occur under Medicaid/HMO contracting since the HMO reimbursement rate can not be higher than the FFS rate.

NORTH CAROLINA

- State has no OBRA 1981 legislative authority
- No HMO contracts

North Carolina does not have OBRA 1981 legislative authority and has no current contracts with any HMOs. The North Carolina State Medicaid Agency does, however, plan to have Medicaid/HMO contracts in the future.

North Carolina had worked with providers in the past to develop a Medicaid/PHP contract but during the final negotiations the providers turned down N.C. Medicaid. The State said the HMOs/PHPs turned down the contract because the capitation rate was too low and the start-up marketing costs were too expensive.

A number of HMOs have recently come into the State and two have expressed an interest in enrolling Medicaid eligibles. The State anticipates that there may be two PHP contracts in Wilson County in 1985 as well as two possible HMO contracts in 1986. The State feels that when they do contract with the HMOs they will not need to use the waiver authority.

The interviewed HMO in North Carolina stated that they have not been, nor are they, interested in Medicaid/HMO contracting because it is not in their operational philosophy to contract with the State. They serve just certain employees and their families.

OHIO

- State contracts with state-qualified HMOs
- Three HMO contracts
- Contracting with HMOs since 1978
- Serve the AFDC Medicaid eligibility group
- 2% of Medicaid population enrolled in HMOs
- Voluntary enrollment
- 1 federally-qualified HMO, 2 state-qualified HMOs

Ohio contracts with HMOs that meet the State definition of a HMO and qualify for FFP as a result of OBRA 1981 legislation.

In 1978, the interviewed HMO approached the State Medicaid Agency about the possibilities of contracting. However, it was not until 1983, when the Commission of Ohio Health Care Costs met to examine Medicaid that HMO contracting was really promoted. At the present time, the State has negotiations in process with six HMOs. The State has also appropriated planning grants to seven organizations to promote Medicaid/HMO contracting. The interviewed HMO's reasons for continuing their Medicaid contract is that they feel they can provide quality health care services to this population.

The State said that one of their barriers to Medicaid/HMO contracting was that, in the past, the HMOs were not very competitive and did not want to expand to include Medicaid eligibles. Now, however, they are finding that the HMOs are more aggressive and are looking at contracting. The interviewed HMO cited barriers to their contracting to be eligibility determination and rates. The HMO has found maintaining the enrollment and disenrollment logs to be very time consuming. Also, the HMO stated that the reimbursement rates are very low and do little more than cover costs.

The HMO feels that one of the major factors leading to their current status of Medicaid enrollment is their committtment to serve the Medicaid population.

Enrollment in the HMOs has been steadily increasing over the years--from 7,900 in 1982 to 20,000 in 1985. The State has seen cost savings from the program but has no strong numbers to offer. Ohio Medicaid does project a $17 million savings over the current two year budget period.

OKLAHOMA

- State has no OBRA 1981 legislative authority
- No HMO contracts

Oklahoma does not have OBRA 1981 legislative authority and has no current contracts with any HMOs. The Oklahoma State Medicaid Agency has no plans in the immediate future to contract with HMOs but contracting is not outside the scope of their long-term plans.

The main reason that Oklahoma has not contracted with any HMOs for their Medicaid population is that they have looked at the Medicaid/HMO experiences of other States and have determined that contracting with HMOs does not work with the Medicaid population. Also, Oklahoma stated that there are only six to eight HMOs in the State and they have not expressed any desire to contract for the Medicaid population.

The interviewed HMO in Oklahoma stated that they have not expressed any desire to contract with the State Medicaid Agency because they do not have any interest in contracting with any public programs.

OREGON

- No OBRA legislative authority but contract with HMOs
- One HMO contract
- Contracting with HMO since 1978
- Serve the AFDC Medicaid eligibility group
- 7.1% of Medicaid population enrolled in HMOs
- Forced choice enrollment
- HMO is federally-qualified

As of September 1984, this study's cut-off date, Oregon had not implemented the 2175 waiver but did have a Medicaid/HMO contract. However, in February 1985 the 2175 waiver was implemented and incorporated into the use of their contracting HMO. The State feels that this waiver will double enrollment and has also encouraged other HMOs to think about contracting.

The contracting HMO approached Oregon to initiate Medicaid/HMO contracting. The HMO continues to contract with the State Medicaid Agency because they feel a committment to serve a cross section of the population which includes the Medicaid population.

The State feels that their major barrier in contracting is that there is no process for state qualifications for HMOs, but legislation has been submitted for this. The contracting HMO cited a few barriers to contracting. Turnover has been a major problem for the HMO because as people left the program, they were not getting new eligibles into the program. The HMO suspects that the case workers may not have been informing eligibles of the HMO option. The HMO also has problems with the rates when the State chooses an artificial value for their fee-for-service experience.

The primary factor leading to the current status of Medicaid enrollment in the HMO is their reputation. People join because they have heard good things about the care and services provided. They also feel that the State contracts with them because they offer better rates and benefits for the same amount of money.

Enrollment has been increasing in Oregon, primarily because of their newly implemented and incorporated freedom-of-choice waiver. Also, there is approximately a $2-3 cost savings per person per month as a result of the Mediciad/HMO contract.

PENNSYLVANIA

- No OBRA legislative authority but contract with HMOs
- Three HMO contracts
- Contracting with HMOs since the early 1970s
- Serve all Medicaid eligibility groups
- .75% of Medicaid population enrolled in HMO
- Voluntary enrollment
- All HMOs are federally-qualified

Pennsylvania has no OBRA legislative authority but does have three Medicaid/HMO contracts. The State did not feel that the OBRA legislative authority was necessary for contracting with HMOs. However, the Department, in cooperation with the Health Insuring Organization (HIO) applied for a case management waiver on April 12, 1985 from the federal government. Under this waiver, a primary care physician will be available to each recipient in the demonstration area. This program will not likely be in full operation prior to October or November 1985.

Contracting began in the State when the Pennsylvania legislature approached the Department of Public Welfare and asked them to develop a plan to increase the Medicaid population in prepaid health plans. The interviewed HMO is unsure of the impetus to their contracting with the State but said they currently contract because they want to provide equal health care for all segments of the population.

The major barrier that the State has experienced in HMO contracting is that the HMOs have a perception that Medicaid clients are sicker, undisciplined and harder to treat. They stated that the HMOs also see contracting as involving alot of red tape, causing an administrative burden on them. The interviewed HMO cited two problems/barriers to their contracting. They have difficulty with eligibility determination and turnover since they lose a number of clients each month to loss of eligibility and because they never know how many eligibles they will have at one time.

The HMO cites their marketing efforts as well as their access to health care as the major factors leading to the current status of Medicaid enrollment in their HMO. They have nine medical groups located throughout the city and seven of them are very convenient to the Medicaid population.

Enrollment has been increasing over the years in the HMOs. In 1980 enrollment was 1,300 and in 1985 enrollment is 12,800. The State also said that cost savings have been achieved since the HMO reimbursement rate can not exceed the cost of providing those same services on a FFS basis.

RHODE ISLAND

- No OBRA legislative authority but contract with HMOs
- One HMO contract
- Contracting with HMO since 1972
- Serve the AFDC, medically needy and foster children Medicaid eligibility groups
- .27% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is federally-qualified

Rhode Island has no OBRA legislative authority but has been contracting with an HMO since 1972. They felt that the 2175 waiver was not needed because they have good community participation of physicians concerning Medicaid patients.

Rhode Island stated that a federal grant was their impetus to Medicaid/HMO contracting as it required the State to enroll Medicaid recipients in HMOs. The contracting HMO stated that they began contracting because they felt a committment to serve a cross section of the population as well as a desire to contract in order to cover their fixed costs. These are also their current reasons for continuing their Medicaid/HMO contract.

The State did not see any major barriers or problems to contracting. One minor problem was that the HMO offers fewer services than the State package and therefore eligibles have to go outside the HMO to obtain certain services. The HMO did not see any major problems with their Medicaid contract since their Medicaid population is small (285 in 1984) and the population has remained fairly stable over the years. One problem that they cited was that the rates that they receive are very outdated. Also the HMO does little marketing and if the eligible is interested in the HMO option, they have to go across town to enroll. Therefore, the person has to make an effort if they want to enroll into the HMO.

The factors the HMO perceives that lead to the contracting HMO's current Medicaid enrollment are that: the enrollees are interested in the HMO since they have to make an effort to join, and the State feels that the fee-for-service plan is cheaper than pre-payment so it is not pushed by the State resulting in a small Medicaid enrollment.

Enrollment has remained fairly stable over the years (251 enrollees in 1982, 268 in 1983 and 285 in 1984). Although no studies have been done, the State said that they have experienced no cost savings in their Medicaid/HMO contracting.

TENNESSEE

- State with 2175 waiver
- No HMO contracts

Tennessee has a 2175 waiver that was implemented in April 1983 and the second year of the waiver was completed on April 1, 1985. Twelve physicians in Maury County participate in a case management program and are reimbursed fee-for-service. The State also has a Home and Community Based (H&CB) Waiver with an August 1985 implementation date in the Memphis area as well as another H&CB waiver in an eastern county. In addition, Tennessee has a contract with a Health Insuring Organization (HIO) that is operating in three counties. Tennessee has not been considering using the 2175 waiver for HMO contracting because they are waiting to see what they learn from their current programs before they start another one.

Tennessee has no current Medicaid/HMO contracts. They did talk with an HMO about two years ago but the HMO was not interested in contracting as they were just getting started. Tennessee stated that they are still open to contracting with HMOs and one HMO is currently exploring the possibility.

The interviewed HMO in Tennessee stated that they do not have any plans to contract in 1985 with the State Medicaid Agency but they are exploring the possibility of contracting in 1986 or 1987. Their main reason for not contracting before was that their HMO was running close to capacity and they did not want to overload the system. The HMO is now capable of handling the Medicaid population. If they did contract with the State, the HMO is unsure if they would like to see the waiver incorporated into their contracting.

TEXAS

- State has no OBRA 1981 legislative authority
- No HMO contracts

Texas does not have OBRA 1981 legislative authority and has no current contracts with any HMOs. The State is currently trying to put together a demonstration project in two counties where they would contract with the two HMOs in these counties. The Medicaid recipients in these areas would have to decide between the two HMO plans. There will be a lock-in once the recipients decide which plan they want. For this demonstration project, Texas will look at the costs and utilization results to see if a HMO is a cost-effective provider of services for this population.

The main reason that Texas has not looked into the possibilities of contracting is that the State has been operating under a Health Insuring Organization (HIO) since 1967 which has been a very effective program in controlling costs. They are now looking at HMOs as they recognize that they could be another vehicle for decreasing costs and controlling utilization.

The interviewed HMO in Texas stated that their main reason for not contracting with the State is that they have been concentrating their efforts on their new Medicare contract and will continue with their present efforts before phasing in any other programs. However, they would consider contracting with Medicaid if given the opportunity to contract.

UTAH

- Has 2175 waiver and uses waiver in HMO contracting
- One HMO contract
- Contracting with HMO since 1977
- Serves all Medicaid eligibility groups
- 9.8% of Medicaid population enrolled in HMO
- Voluntary enrollment
- HMO is federally-qualified

Utah has implemented the 2175 waiver and incorporates the waiver in their HMO contracting. They chose to apply for this waiver in order to provide case management to allow the State to require recipients to choose a primary care provider from among the fee-for-service (FFS) physicians and the HMO. The contracting HMO feels that this freedom of choice waiver probably helped increase their enrollment as it went from approximately 5,000 in 1980 to 7,500 in 1983.

The State's impetus to contracting began with the Community Health Group. They recieved a subsidy under 314(e) which deals with the low income non-Medicaid population. This was the origin of the HMO concept in Utah. Also, Utah completed a study focusing on HMOs that recommended Medicaid enrollment in HMOs. The HMO became interested in contracting with the State Medicaid Agency because the HMO was initially established to serve the indigent population and the contract would further this intention. The HMO continues to contract with the State as their committment to serve this group remains the same.

The major barrier that the State cites to contracting is the perception of the medical community of Medicaid recipients because the HMOs do not want to become labeled as a low income provider of health care. Utah's contracting HMO does not cite any major problems to contracting, only a minor one. They feel that marketing to the Medicaid population is a costly process. Also, the State has expressed a desire undertake the marketing of the HMO but the HMO feels that it is in their best interest to do the marketing as they have the experience and capability.

The HMO feels that one of the major factors leading to the current enrollment of their Medicaid population is that they provide quality services while, at the same time, providing a cost savings to the State.

When the FOC waiver was implemented and used in HMO contracting, the HMO enrollment increased but has, for the most part, remained fairly stable at approximately 7,000 over the past few years. Also, contracting has resulted in a cost savings to the State but this amount has not been determined.

VIRGINIA

- State has no OBRA 1981 legislative authority
- No HMO contracts

Virginia did not have OBRA 1981 legislative authority as of this project's cut-off date, September 1984, and has no current contracts with any HMOs. However, the State has recently implemented a 2175 waiver but has not considered this provision to use as a vehicle to contract with HMOs. The Virginia State Medicaid Agency stated that they have no immediate plans to contract with any HMOs.

Virginia stated that they do not contract with HMOs because they feel that the HMOs do not provide the level of care that the State desires for the Medicaid population. Also, the State feels that the HMOs are not interested in contracting.

The interviewed HMO in Virginia stated that they have not considered Medicaid contracting a top priority because they are a new organization, having just negotiated some federal contracts and are concentrating their efforts on these projects. They did state, however, that they would definitely look into the possibilities of Medicaid contracting if they were approached for contracting.

WASHINGTON

- State has 2175 waiver but does not incorporate the waiver in HMO contracting
- Three HMO contracts
- Contracting with HMOs since the 1960s
- Serve the AFDC-CN eligibility group
- 1.8% of Medicaid population enrolled in HMO
- Voluntary enrollment
- Two HMOs federally-qualified, one grandfathered in as a result of contracting with Medicaid prior to the HMO provision

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Washington has implemented a 2175 waiver but does not incorporate the waiver in their HMO contracting. The State is currently preparing a waiver application for use in a Health Insuring Organization (HIO) with Primary Care Physicians (PCPs). They have applied for this waiver to restrict the choice of providers. The state has a separate 2175 waiver that is a prepaid capitation plan to pay for prescription drugs provided to recipients in selected long-term facilities.

The HMOs were the first party to express an interest in Medicaid contracting because the State could pay a competitive rate for enrollees. Three HMOs were interviewed in this State and they all stated that their current reason for contracting was their committment to serve the Medicaid population.

The State felt that their major barrier/problem in contracting is the Federal capitation since they can not offer a rate that is more than the rate for similar services for similar populations. All three HMOs also cited the rate reimbursement as a problem in contracting as they are not getting paid the rates they need. All three HMOs have problems with marketing. The State handles all the marketing for two HMOs so they do not have an opportunity to reach this population, the other HMO feels that some of the regional offices are not interested in promoting the HMO option. All of the HMOs cite turnover of their Medicaid population as a problem since there is no extended eligibility.

The HMOs all offered various factors for their current Medicaid enrollment. One HMO states that they will not look to increase their enrollment until the State creates the right incentives for them to provide services to this population. The second HMO cites administrative issues (i.e. eligibility determinations) and premium issues (i.e. rate setting) as affecting their Medicaid enrollment. The third HMO, that had less problems in contracting, felt that their reputation and quality services were major factors.

Enrollment has been decreasing over the years--6,150 in 1982 to 5,250 in 1985. Also, Washington is not currently experiencing any cost savings in the program.

WISCONSIN

- Has 2175 waiver and uses waiver in HMO contracting
- State provides extended eligibility for one month
- State contracts with state-qualified HMOs
- Thirteen HMO contracts
- Contracting with HMOs since 1984
- Serve the AFDC Medicaid eligibility group
- 20.7% of Medicaid population enrolled in HMOs
- Forced enrollment
- 9 HMOs are State-qualified, 4 are Federally-qualified

Wisconsin has implemented the 2175 waiver and incorporates the waiver in their HMO contracting. The waiver permits the State Agency to act as prudent purchaser of primary health care services by contracting with HMOs to act as case managers. Medicaid recipients are enrolled in HMOs that have entered into contracts with the State. This waiver is being implemented in Dane and Milwaukee Counties. The State has all of the AFDC population enrolled in these areas in HMOs as of May 1985. In 1986, this program will be expanded to another county and will expand to a fourth county in 1987.

Wisconsin provides benefits to categorically needy recipients who are enrolled in a federally-qualified HMO and who become ineligible for Medicaid, for a period on one month.

The State contracts with federally-qualified HMOs as well as HMOs that meet the State definition of a HMO and qualify for FFP as a result of OBRA 1981 legislation.

Medicaid/HMO contracting began because both the State and the HMOs were interested in contracting. One barrier that both parties cite to this contracting is the absence of a 6-month extended eligibility as this would help the HMOs turnover problem. The HMOs cited eligibility determination as a problem since it is not a timely or accurate process. Also, the contracting process was a problem for the HMOs since they are unable to provide much input into the contract development process.

The FOC waiver was one factor mentioned by the HMOs leading to the current Medicaid enrollment in the HMOs as well as their committment to serving this segment of the population.

Enrollment has been increasing in the HMOs--from zero in 1983 to 101,796 in 1985. The State is currently at full enrollment in their HMOs. The State expects to save approximately $10 million dollars between 1985 and 1987 on HMO contracting.

CHAPTER FIVE
ISSUES ANALYSIS

A. EFFECTS OF LEGISLATIVE CHANGES

HMO/State Medicaid Agency contracting began as early as the late 1960s and as recently as this year. The contracting experiences vary widely as the environments in which the HMOs and the Medicaid Agencies operate have been unique.

One of the factors that causes each HMO/Medicaid Agency contract to be unique is the OBRA 1981 legislation that the State Medicaid Agencies have implemented or have not implemented and how they incorporate the legislation into HMO contracting. Table 1 illustrates the State Medicaid Agencies' implementation of the OBRA legislation. The three OBRA legislative authorities are: Section 2175 Waiver, extended eligibility, and State-qualified HMOs. State Medicaid Agencies have the option of implementing any one or all of these provisions.

Ten interviewed State Medicaid Agencies (MAs) have implemented Section 1915(b) of the Social Security Act (OBRA Section 2175 waiver) but only three of the State MAs incorporate this legislative authority in HMO contracting. Three of the other State MAs have HMO contracts but do not use the 2175 Waiver and the remaining four State MAs do not contract with HMOs.

Five State Medicaid Agencies have implemented the OBRA six-month guaranteed provision. These State MAs provide extended eligibility to their HMO/Medicaid enrollees for a period of one to six months, depending on the State Medicaid Agency. Nine interviewed State MAs contracted with State-qualified HMOs under OBRA.

However, there are characteristics of HMO/Medicaid Agency activities that are common between States. Table 2 displays the characteristics of the HMO/Medicaid Agency activities in the States. The common characteristics identified from this Table are:

- The HMOs primarily serve multiple counties;
- The HMOs primarily serve the AFDC Medicaid eligibility group only;
- Enrollment is usually voluntary;

TABLE 1

MEDICAID AGENCIES' IMPLEMENTATION OF OBRA 81 LEGISLATION

Group STATE	2175 WAIVER	EXTENDED ELIGIBILITY	STATE QUALIFIED HMOs
Group 1			
New York[1]	X		X
Utah	X		
Wisconsin[2]	X	X	X
Group 2			
Connecticut		X	
Indiana		X	
Minnesota[3]		X	X
New Hampshire		X	
Group 3			
California			X
Illinois			X
Maine			X
Maryland			X
Massachusetts			X
Ohio			X
Group 4			
Colorado	X		
Michigan	X		
Washington	X		
Group 5			
Kansas	X		
Kentucky	X		
Nevada	X		
Tennessee	X		

[1] New York - This State also meets group 3 characteristics

[2] Wisconsin - This State also meets group 2 & 3 characteristics

[3] Minnesota - This State also meets group 3 characteristics

TABLE 2
STATES SURVEYED AND CHARACTERISTICS OF HMO/MEDICAID ACTIVITIES

GROUP STATE	Geographic Area Served	Eligibility Group Served	Enrollment Options	Medicaid Enrollment in HMOs in 1984* or 1985	Marketing	Rate Setting
Group 1						
New York[1]	2		1	50	3	3 & 4
Utah	2	3	1	6,806*	3	3
Wisconsin[2]	2	1	2	101,796	3	4
Group 2						
Connecticut	1	1	1	391	3	4
Indiana	2	1	1	3,021*	3	2
Minnesota[3]	2	1	1	6,000	3	4
New Hampshire	7	4	1	529*	3	3
Group 3						
California	2	3	1	198,379*	4	4
Illinois	1	1	2	56,114*	1	2
Maine	1	1	1	444*	3	3
Maryland	2	3	1	15,106	3	4
Massachusetts	2	4	1	4,293	3	3
Ohio	2	1	1	20,000	3	4
Group 4						
Colorado	2	3	1	5,580*	2	3
Michigan	2	3	1	92,181*	3	4
Washington	2	1	1	5,350	2	3
Group 6						
District of Columbia	1	1	1	142*	1	3
Oregon	2	1	2	10,000	2	4
Pennsylvania	2	3	1	12,800	3	3
Rhode Island	3	4	1	285*	2	3

CODE:

* Denotes 1984 data.

Geographic Area Served
1=One County
2=Multiple Counties
3=State

Eligibility Group Served
1=AFDC Only
2=AFDC and SSI
3=All Groups
4=AFDC & Other

Enrollment Options
1=Voluntary
2=Forced Choice
3=Mandatory

Marketing
1=HMO Only
2=Medicaid Agency (MA) Only
3=HMO and MA
4 County Eligibility Office

Rate Setting
1=Competitive Bid
2=Competitive Bid with cap set by State
3 Negotiated Rate
4=Set by State

- Marketing is usually a cooperative effort between the State Medicaid Agency and the HMO; and
- Rates are usually negotiated or set by the State Medicaid Agency.

Geographic Areas Served. Of the twenty State Medicaid Agencies that were interviewed, approximately seventy-five percent stated that the HMO/Medicaid contracts served multiple county areas. Only one State's HMO/Medicaid Agency contract provided statewide health care services.

Eligibility Groups Served. Fifty percent of the State Medicaid Agencies stated that they offer the HMO option to their AFDC Medicaid eligibility population only, while approximately thirty percent of the State MAs offer the HMO program to all their Medicaid eligibility groups. Some States, such as Massachusetts and Rhode Island offer the HMO option to the AFDC population as well as "other" groups such as refugees and foster children.

Enrollment Options. Enrollment in the HMO program is voluntary in ninety percent of the State MAs and a forced choice is made in the rest. There does not appear to be a strong relationship between the enrollment option (i.e. voluntary) and the number of Medicaid eligibles in the HMO programs. Nor does there appear to be a strong relationship between the eligibility group served and the number of Medicaid eligibles in the program. There are instances where State MAs that offer the HMO option in various counties and to all eligibility groups have a large number of Medicaid enrollees in the HMOs, but this is not always the case in similar cases.

Marketing. Marketing can be done by the HMO, the State Medicaid Agency, cooperatively by both parties, or primarily by the County. The most common marketing approach is the joint marketing effort. In this way, the HMO and Medicaid Agency can market more effectively and can reach more eligibles.

Rate Setting. The determination of the reimbursement rate is also an important factor in the HMO/Medicaid contracts. State MAs enter into contracting in an effort to provide quality services to Medicaid recipients but also to establish a more cost-effective Medicaid program. HMOs also have a financial incentive to enter into a HMO/Medicaid contract. Approximately forty-five percent of the State MAs set the captitation rate and forty-five percent of the State MAs negotiate the reimbursement rate with the HMO. Very few State MAs use the competitive bid process with a cap set by the Medicaid Agency and there were no State MAs interviewed that set the rate by a competitive bid.

Comparing the States with OBRA leigislative authority that have HMO/Medicaid contracts (Groups 1,2 and 3) to the States with no OBRA legislative authority that have HMO/Medicaid contracts (Groups 4 and 6), there appears to be no strong distinction in the characteristics and HMO/Medicaid activities between the two groups.

The State MAs and HMOs have different reasons for contracting as well as different objectives they wish to accomplish with their contracts. As these tables have shown, a variety of options are available to each HMO and State Medicaid Agency and they are able to tailor these options to meet their individual goals.

B. PROCESSES USED BY CONTRACTING HMOs AND STATE MEDICAID AGENCIES

1. Eligibility

The State Medicaid Agency (MA) can select from a number of Medicaid eligibility groups to be served in the HMO/Medicaid contract. Some Medicaid Agencies offer the HMO program to only one Medicaid eligibility group (i.e. AFDC) while other State MAs offer the HMO program to all Medicaid eligibility groups. Once the Medicaid Agency determines which Medicaid eligibility groups will participate in the HMO program, they then develop procedures to inform the Medicaid eligible of the HMO option/forced choice and to inform the HMO of the client's eligibility. Table 3 illustrates the parties involved in the eligibility determination. In eighty-five percent of the States, the actual Medicaid eligibility determination is done by the State MA. In fifteen percent of the States, eligibility determination is handled at the County level.

The procedures for informing the HMO of the Medicaid member's Medicaid eligibility vary between State Medicaid Agencies but there are generally two ways that members enroll and are determined eligible to the HMO program.

In the first method, the Medicaid eligible contacts the HMO of their interest in the HMO option. The HMO will then send the eligible an enrollment application. Upon receipt of the enrollment application, the HMO will notify the State and/or County Medicaid Agency who will then check on the individual's Medicaid eligibility. If determined eligible, the State Medicaid Agency or County will notify the HMO of their eligibility and will indicate the effective date of HMO enrollment for the eligible. This notification process varies somewhat among the State MAs but generally the HMOs are sent a regular list of all Medicaid eligibles and then, if anyone enrolls into the HMO program, the HMO just needs to check their eligibility list.

TABLE 3

ELIGIBILITY

GROUP STATE	ELIG. DETERMINATION by County	 by State	Time Lags	ELIG. NOTIFICATION BARRIERS Perceived by State	 Perceived by HMO
Group 1					
New York[1]		X			N/A
Utah		X			
Wisconsin[2]		X			X
Group 2					
Connecticut		X			N/A
Indiana		X	X		
Minnesota[3]		X			
New Hampshire		X			X
Group 3					
California		X	X		X
Illinois		X			
Maine		X			X
Maryland		X			
Massachusetts		X			X
Ohio	X			X	X
Group 4					
Colorado	X		X	X	X
Michigan		X			X
Washington		X			X
Group 6					
District of Columbia		X			
Oregon		X			
Pennsylvania	X				X
Rhode Island		X			

[1] New York - This State also meets Group 3 Characteristics

[2] Wisconsin - This State also meets Group 2 & 3 Characteristics

[3] Minnesota - This State also meets Group 3 Characteristics

Another method that is used to inform the HMO of a Medicaid enrollee's eligibility is when the individual enrolls into the HMO program at the eligibility office. After the eligible enrolls, the State MA then can call and/or confirm in writing to the HMO the individuals that are enrolled into the HMO program.

The time period varies among State Medicaid Agencies as to how often the HMOs are updated on Medicaid clients eligible for the HMO. Some State MAs have weekly lists, while others have monthly lists. There is also a time lag from when the State MA receives the HMO enrollment information to the time where the eligible is put into the system and the HMO receives the information. This process can take up to 30-45 days in some State MAs. This lag time is difficult for some HMOs since they do not always know that the individual is enrolled or if the individual is indeed "Medicaid eligible."

The eligibility process in HMO/Medicaid contracting for the thirteen States that have OBRA 1981 legislation and the seven States that do not have OBRA 1981 legislation does not differ significantly between the groups.

HMOs' Perceptions. Fifty percent of the interviewed HMOs cited the eligibility notification process as a barrier. The major problems cited by the HMOs were that eligibility notification has not been timely, accurate or available. HMOs stated that this problem becomes a costly and time consuming process since they can not always rely on the information they have.

Medicaid Agencies' Perceptions. Only ten percent of the State Medicaid Agencies cited the eligibility notification process to be a barrier and/or problem in contracting. Both Colorado's and Ohio's Medicaid Agency are in the process of remedying this problem by improving the computerized eligibility system. Both feel that the eligibility determination process will become less time consuming and will decrease the amount of paperwork for the HMO as well as for the State.

2. Benefit Package

HMOs are required to make their services available to Medicaid enrollees to the same extent they are available from other sources to nonenrolled Medicaid recipients in the area. However, HMOs are not necessarily required to furnish all services directly. Selected services are furnished in some States by the HMO contracting with additional providers, by the State Medicaid Agency contracting with additional providers, or by the State MA paying FFS to certain providers. Also, the HMO

TABLE 4

BENEFIT PACKAGE

GROUP STATE	HMO Benefit package LARGER than State FFS package	HMO Benefit package SMALLER than State FFS Package	SAME or COMPARABLE benefit package	SERVICES NOT PROVIDED BY HMO BUT REQUIRED			BENEFIT PACKAGE BARRIERS	
				Contracted by HMO	Contracted by State	Paid FFS by State	Perceived by State	Perceived by HMO
Group 1								
New York[1]			X			X	X	N/A
Utah		X			X			
Wisconsin[2]			X					
Group 2								
Connecticut		X				X		N/A
Indiana	X			X				X
Minnesota[3]			X					
New Hampshire	X					X		
Group 3								
California	X					X		
Illinois			X			X		
Maine			X					
Maryland	X							
Massachusetts		X				X	X	
Ohio	X							
Group 4								
Colorado	X					X		
Michigan	X					X		
Washington	X					X		
Group 6								
District of Columbia			X					
Oregon		X				X		
Pennsylvania			X			X		
Rhode Island		X				X	X	

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

may cover services to enrolled recipients that are not provided under the plan to nonenrolled recipients.

As is seen in Table 4, approximately 40% of the HMO/Medicaid contracts had benefit packages that were larger than the State FFS package, 35% had the same or a comparable benefit package, and 25% of the HMO/Medicaid contracts had a benefit package that was smaller than the State FFS package.

For the health care services that are not provided by the HMO but are required Medicaid benefits, HMOs can provide these services to their Medicaid clients in a number of ways. The services can be contracted by the HMO, they can be contracted by the State MA, or they can be paid FFS by the State Medicaid Agency. When the States had HMO/Medicaid contracts that did not provide all the required Medicaid benefits, the services were all paid FFS by the State MA with the exception of two State MAs--Indiana and Utah. In these two cases, Indiana's HMO contracted for the services, while Utah's MA contracted for the services directly.

Three State MAs and one HMO, all in different groups, perceived barriers to HMO/Medicaid contracting as a result of the benefit package. Two State MAs, Massachusetts and Rhode Island, contracted with HMOs that had benefit packages smaller than the State FFS package. They felt that the State MAs comprehensive package was a barrier to contracting since their HMO/Medicaid enrollees had to go outside the HMO for certain services. The New York HMO service package was comparable to the State Medicaid benefit package but since the State MA had such liberal benefits, clients perceived that they were still losing something by joining the HMO. The one HMO perceived a barrier to the benefit package because they could only offer one additonal service to the package and this service did not provide any real incentive for the Medicaid eligible to enter into their HMO program.

The range of services that the HMOs provide in addition to covered Medicaid benefits vary but the most common services are health education, health promotion and health prevention services.

The benefit package provided by the States with OBRA 1981 legislation (Groups 1,2, and 3) and the States with no OBRA 1981 legislation (Groups 4 and 6) were very similar in the service packages offered as well as in the services not offered by the HMO but required by the State Medicaid Agency.

3. Reimbursement

As part of the contract development process, the HMO reimbursement rate must be determined. This rate usually represents the total obligation of the State Medicaid Agency with respect to the costs of medical care and services provided to Medicaid recipients enrolled in the HMO program.

The Federal regulations the State Medicaid Agencies must adhere to in setting the rate is that the cost may not exceed the cost of providing the same services on a fee-for-service basis to an equivalent nonenrolled population group. However the actual variables considered to determine equivalency are not the same for each State MA. State MAs have different methods for setting the rates, different indexes for basing the rates, and different factors to include in the rate determination. The most common methods and factors identified in Table 5 are:

- Rates are negotiated or set by the State Medicaid Agency in 50% of the cases;
- Rates based on fee-for-service costs in 70% of the cases; and
- The eligibility group and geographic location are the most common factors used to determine the equivalent fee-for-service basis.

Rates are generally set by the State Medicaid Agency in one of four ways: competitive bid, competitive bid with an upper limit set by the State MA, negotiated rate, or a rate set by the Medicaid Agency. Approximately 90% of the State MAs said that their rates are either set by them or are negotiated by them and the HMO during contract development. Only 10% of the State MAs set the rate by a competitive bid putting an upper limit of the rate and there were no State Medicaid Agencies where the rate was set solely by a competitive bid.

Rates are based on three major factors: community rate, average adjusted per capita cost (AAPCC), or fee-for-service (FFS) cost. Fifteen percent of the State MAs used more than one factor in their rate determination--New Hampshire, Massachusetts, D.C., and Pennsylvania used the community rate only; Ohio used the AAPCC; New York used the community rate and an "other" actuarial method and the other State MAs based their rates on FFS and an "other" actuarial method. Approximately 70% of the Medicaid Agencies used the FFS in their rate determination, followed by twenty percent of the State MAs using the community rate in their determination.

The major factors that were included in rate determination were: eligibility group, geographic location, age, and sex. Ninety percent of the State Medicaid Agencies used more than one

TABLE 5

REIMBURSEMENT

GROUP STATE	Range of Capitation Rates (monthly)	Rates Set By				Rates Based On				Factors In Rate Determination					Risk Assumed by HMO	Stop Loss Agreement	State Provided Reinsurance	Dummy Claims	Barriers to Reimb.	
		Competitive Bid	Comp. Bid with Upper Limit	Negotiated Rate	Set by State	Community Rate	AAPCC	FFS	Other	Eligibility Group	Geog. Location	Age	Sex	Other					Perceived by State	Perceived by HMO
Group 1																				
New York1	$60-80	-	-	X	X	X	-	-	X	X	X	-	-	-	Varies	X	X	-	-	N/A
Utah	$66.35-191.04	-	-	X	-	-	-	X	X	X	-	-	-	X	Full	-	-	-	X	-
Wisconsin[2]	$51.07-68.35	-	-	-	X	-	-	X	-	X	X	-	-	-	Full	X	X	X	-	X
Group 2																				
Connecticut	$62.77	-	-	-	X	-	-	X	-	X	X	-	-	-	Full	X	-	-	-	N/A
Indiana	$62.94	-	X	-	-	-	-	X	-	X	X	-	-	-	Full	X	X	-	-	X
Minnesota[3]	$47.24-68.87	-	-	-	X	-	-	X	-	X	X	X	X	-	Full	X	X	X	-	X
New Hampshire	$50.87	-	-	X	-	X	-	-	-	X	-	-	-	X	Shared	-	-	-	-	-
Group 3																				
California	$41.71-147.64	-	-	-	X	-	-	X	X	X	X	X	X	-	Up to 25K	X	X	-	X	X
Illinois	$58-61	-	X	-	-	-	-	X	-	X	X	-	-	-	Full	X	-	-	-	X
Maine	$45.34	-	-	X	-	-	-	X	-	X	X	X	X	-	Full	X	-	-	-	-
Maryland	$57.76-116	-	-	-	X	-	-	X	-	X	X	-	-	-	Up to 7K	X	-	-	X	-
Massachusetts	$51-76	-	-	X	-	X	-	-	-	X	X	-	-	-	Full	X	-	X	-	-
Ohio	$56.48-73.81	-	-	-	X	-	X	-	-	X	X	-	-	-	Full	X	-	-	-	X
Group 4																				
Colorado	$63-73	-	-	X	-	-	-	X	-	X	X	-	X	-	Full	-	-	-	-	X
Michigan	$13.52-285.80	-	-	-	X	-	-	X	-	X	X	X	X	-	Full	-	-	-	-	X
Washington	$50-57.65	-	-	X	-	-	-	X	-	X	X	-	-	X	Full	-	-	-	X	X
Group 6																				
District of Columbia	$68.48-71.51	-	-	X	-	X	-	-	-	-	-	-	-	X	Full	-	-	-	-	X
Oregon	$17.25-53.41	-	-	-	X	-	-	X	-	X	X	-	-	X	18 IP Days	-	X	-	-	X
Pennsylvania	varies	-	-	X	-	X	-	-	-	X	X	X	X	-	Full	X	-	X	-	-
Rhode Island	$32.74	-	-	X	-	-	-	X	-	X	-	-	-	-	Full	-	-	-	-	X

[1] New York - This state also meets Group 3 characteristics.

[2] Wisconsin - This state also meets Group 2 and 3 characteristics.

[3] Minnesota - This state also meets Group 3 characteristics.

factor in their rate determination and the major factors used were: eligibility group (95%) and geographic location (80%). Age and sex were included as factors 25% and 30%, respectively.

An important aspect of the HMO contract is the assumption of risk by the HMO to provide for health care services required by their enrolled clients. Seventy-five percent of all the State Medicaid Agencies require the HMOs to assume full risk for their enrolled Medicaid population. Some HMOs however, negotiate with the State MA on service limitations and certain exclusions in the State Medicaid plan. Reinsurance and a risk pool help protect HMOs from risk. Thirty-five percent of the HMOs are provided reinsurance by the State. Approximately sixty percent of the State MAs have a "stop-loss" provision in the HMO contracts. This provision limits the HMOs' liability for their expenditures on individual Medicaid recipients.

Once the reimbursement rate is determined, the HMO receives a monthly payment for each person covered by the State Medicaid Agency. The capitation rates vary depending upon the group being served and the services rendered. The State MAs with the widest range of capitation rates are those where the HMOs are serving all Medicaid eligibility groups. HMOs that are serving just one population (i.e. AFDC) usually have the narrowest capitation range.

Dummy claims are required by five of the twenty States' Medicaid Agencies. Those State MAs are Wisconsin, Connecticut, Minnesota, Massachusetts, and Pennsylvania. Dummy claims are person level encounter data and provide the Medicaid Agency with sufficient detail to monitor quality and cost of care much more effectively.

The reimbursement process in HMO/Medicaid contracting does not differ greatly between the States with OBRA 1981 legislation and the States with no OBRA 1981 legislation.

HMOs' Perceptions. Sixty-five percent of the HMOs cited reimbursement to be a problem in their contracting. Reasons ranged from: being unable to provide any input, outdated rates, inadequate data on which to base rates, and inadequate rates.

Medicaid Agencies' Perceptions. Twenty percent of the State Medicaid Agencies cited reimbursement as a problem and/or barrier in contracting. The problem is usually that the State MA and/or the HMO sees the capitation rate too low or just barely covering costs.

4. Contract Development and Implemenation

State Medicaid Agencies and HMOs initiate contracting for a variety of reasons and these reasons for contracting as well as the party initiating the contracting seem to have an effect on the success of the contracting process.

As seen in Table 6, in thirty percent of the States, the HMOs and State MAs stated that the State was the major impetus to the contracting process. In these States, the MA approached HMOs in the State with the possibilities of contracting and the HMOs and State Medicaid Agencies were fairly successful in establishing a contract with their first efforts. There were some instances where the State MA approached HMOs who were not initially interested, but later returned to the Medicaid Agency expressing an interest.

In twenty-five percent of the States, it was the HMOs that were responsible for initiating the contracting process. In some of these States, the HMOs were already serving Medicaid clients in some capacity and decided that it was in their best interest to contract with the State Medicaid Agency.

In twenty-five percent of the States, an outside influence was the impetus of the contracting. The results of a national study caused one State to think about contracting while another State became encouraged about the possibilities of contracting from a Medicaid conference.

It appears that contracting was initiated more successfully when the political enrironment within the State encouraged contracting. When the State Medicaid Agency had the backing of the State administration and the legislature, they were more likely, than other State MAs, to actively seek and approach HMOs about the benefits and advantages of contracting.

State Medicaid Agencies wishing to contract with HMOs usually negotiate and administer the contracts based on past experiences and current practices. However, States can only enter into formal negotiations with those groups that are currently licensed to operate in that State. Prior to HMO contracting, the State Medicaid Agency needs to develop administrative rules to govern contracts. Policies on several issues need to be negotiated and settled between the State MA and the HMO before the contract can be implemented. Some of the contract terms that need to be addressed during contract development include: reimbursement rate, payment, monitoring, services covered, marketing, and contract termination.

There are primarily four types of models that Medicaid Agencies rely on for contract development. They are the: Federal

TABLE 6
CONTRACT DEVELOPMENT AND IMPLEMENTATION

GROUP STATE	CONTRACT DEVELOPMENT					IMPLEMENTATION PROBLEMS	CONTRACT DEVELOPMENT BARRIERS		IMPETUS
	use fed'l model contract	use fed'l contract with modifications	use state standard model contract	negotiated by all parties	other		Perceived by State	Perceived by HMO	
Group 1									
New York[1]				X			X	N/A	4
Utah			X						5
Wisconsin[2]		X						X	3
Group 2									
Connecticut		X						N/A	1
Indiana			X			X		X	2
Minnesota[3]			X					X	1
New Hampshire				X			X	X	1
Group 3									
California			X				X	X	5
Illinois					X			X	5
Maine			X				X		3
Maryland			X				X		1
Massachusetts			X				X		5
Ohio			X					X	2
Group 4									
Colorado				X					2
Michigan			X						1
Washington				X				X	2
Group 6									
District of Columbia			X						1
Oregon				X					2
Pennsylvania			X				X		4
Rhode Island			X						5

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

Impetus
1 = State
2 = HMO
3 = State/HMO
4 = State Legislature
5 = Other

contract model, Federal contract model using State modifications, State standard model, or a negotiated contract.

The majority of State MAs (60%) said that they used a State standard model contract when developing a HMO/Medicaid contract. This contract has usually been revised over the years as the State MAs developed more contracting experience. The original model HMO/Medicaid contracts were developed in a variety of ways. Some States MAs developed the contract "as they went along" while other State MAs developed their own model contract based on examples of other State model contracts. The State Medicaid Agencies also vary on the amount they will negotiate and change the standard contract for the HMO. Some MAs will make changes while others try not to make any changes to the model.

The second approach used by Medicaid Agencies when developing contracts was negotiating by all parties. Twenty-five percent of the States fit this category. In these cases, the contracts were usually developed by the Medicaid Agencies and the HMO, and needed approval of all involved parties before it was accepted.

Two State MAs used the Federal contract but made State-specific adaptations to the contract so it could be used. There were no State MAs that used the Federal contract model without making any modifications. This seems to indicate that HMO/Medicaid contracting is a very individual process and in order to develop an appropriate and effective contract, the State Medicaid Agency needs to tailor the contracts to fit their own requirements and needs.

Only one State Medicaid Agency cited a problem in the implementation of the contract and this State MA's implementation problem arose due to trouble with the information systems. There were, however, some barriers cited by the HMOs amd State Medicaid Agencies concerning contract development.

HMO/Medicaid contracting between the States with and without OBRA legislation did not differ in the contract development process. There were however, more contract development barriers perceived by State MAs and HMOs with OBRA legislation.

HMOs' Perceptions. Forty percent of the HMOs perceived problems and/or barriers to contract development. Alot of these problems were related to negotiations on the proposed reimbursement rate on the contract or the fact that the State left little to no room for the HMO to provide any input into the contracting process.

Medicaid Agencies' Perceptions. Thirty-five percent of the States perceived problems and/or barriers to contract development. Some States felt that the development and negotiation was too time consuming while other States felt the problems arose because contract development was still a learning process for them and resulted in slow contract processing.

In the perception of problems related to contract development, there were only two instances where the State MA and the correspondng HMO both cited this to be a problem for them. It appears that the different factors involved in contract development cause different problems for different parties.

5. Contract Monitoring

Monitoring of HMOs by the State Medicaid Agencies usually has a twofold purpose. First, the State MA wants to monitor the HMOs' health care delivery system in order the assure that appropriate and quality care is being delivered to their Medicaid population. Second, the State MA wants to monitor the financial condition of the HMO to ensure that it is a fiscally sound and solvent organization. With monitoring, the State MA can identify, assess and correct problems.

State Medicaid Agencies usually limit their monitoring activity to reporting requirements and on-site visits/audits. Reports from HMOs are State-specific and differ in terms of the type of reports requested as well as the time period requested. The reports vary from financial to statistical to utilization reports. The requested time frame ranges from monthly to annual requirements depending on the State MAs contract specifications. On-site visits/audits also vary among State Medicaid Agencies.

As seen in Table 7, ninety-five percent of the State MAs in our sample indicated some type of reporting requirement in the HMO/Medicaid contracts. Approximately fifty percent of these State MAs required annual reports in addition to monthly and/or quarterly reports. Only Colorado's had no reporting requirements for the HMOs but was in the process of specifying future reporting requirements.

HMO monitoring by on-site visits/audits range from periodic on-site visits to annual on-site visits/audits. Seventy five percent of the State MAs conducted annual on-site visits/audits. These site visits ranged from general medical audits to more detailed inspections of medical records, physical plant, peer review activity, quality assurance programs and financial audits. Only Minnesota had not started on-site monitoring of HMOs.

TABLE 7

CONTRACT MONITORING

GROUP STATE	MONITORING										BARRIERS TO REPORTING REQ.	
	REPORTING REQUIREMENTS						SITE VISITS					
	Monthly Reports Required	Quarterly Reports Required	Semi-Annual Reports Required	Annual Reports Required	No Reports Required	Other	Periodic On-Site Visits/ Audits	Annual On-Site Visits/ Audits	No On-Site Visits/ Audits	Other	Perceived by State	Perceived by HMO
Group 1												
New York[1]						X		X			X	N/A
Utah			X					X				
Wisconsin[2]						X		X				X
Group 2												
Connecticut			X					X				N/A
Indiana	X							X				
Minnesota[3]						X			X			X
New Hampshire		X						X				
Group 3												
California	X	X		X				X				X
Illinois	X			X						X		
Maine	X	X		X				X			X	
Maryland		X				X				X		
Massachusetts						X		X				
Ohio				X				X				
Group 4												
Colorado					X			X				
Michigan		X		X			X					
Washington		X						X				
Group 6												
District of Columbia				X						X		
Oregon		X		X				X				
Pennsylvania		X						X				
Rhode Island				X				X				

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

Contract monitoring does not differ greatly between the States with OBRA 1981 legislation and the States without OBRA 1981 legislation. Some of the State MAs with OBRA legislation, however, did require more reports than some of the State MAs with no OBRA legislation.

HMOs' Perceptions. Fifteen percent of the HMOs perceived the reporting requirements to be a barrier to their HMO/Medicaid contracting. Some HMOs felt that the reporting requirements were cumbersome and very time consuming, especially for those HMOs that manually abstract data. Other HMOs stated that their State MA had an absence of uniform reporting requirements which proved to be a problem for them.

Medicaid Agencies' Perceptions. Ten percent of the State MAs cited reporting requirements as a barrier to HMO/Medicaid contracting. One State MA cited a contracting HMO's unfamiliarity with their reporting requirements as a problem while another Medicaid Agency felt that their requirements were too loose and were pushing for more systematic reporting from the HMOs.

6. Marketing

An effective marketing approach is important to the success of the HMO/Medicaid contract. As the HMO concept is still a fairly new concept, especially among the Medicaid population, it is essential that Medicaid eligibles understand the HMO concept and the advantages of enrollment into such a program in order to make an informed decision about whether or not to enroll.

Table 8 illustrates the degree of marketing effort by the State MA and the HMOs and how it varies among the States. The most common marketing approach in the States was a cooperative effort between the State Medicaid Agency and the HMO. In these cases, the HMO dealt more with site-specific efforts as they had direct contact with the Medicaid enrollees and the State MA would help with the larger media campaign by assisting HMOs in efforts such as developing marketing plans and strategies, producing information booklets of their programs, and doing public relations in the various communities. This method appears to work best when the State MA makes different marketing arrangements with each of the HMOs depending on the HMO's marketing needs.

Another marketing approach was when the State Medicaid Agency did the majority of the marketing of the HMO option. Twenty percent of the State MAs took this approach in marketing. Of the States that had the State Medicaid Agency doing most of the marketing, it was sometimes the option of the HMO not do take an active role in marketing, and in other States, the Medicaid

TABLE 8

MARKETING

GROUP STATE	DEGREE OF MARKETING EFFORT				MARKETING TOOLS USED							MARKETING BARRIERS	
	State Medicaid Agency (SMA) does Majority	HMO does Majority	Cooperative Effort by SMA & HMO	Other	Videotape or slide presentations	Advertisements	Brochures	Mass Mailings	Representative at County Office	Door to Door	Other	Perceived by State	Perceived by HMO
Group 1													
New York[1]			X		X	X	X						N/A
Utah			X		X		X		X				X
Wisconsin[2]			X				X	X					
Group 2													
Connecticut			X		X		X	X			X		N/A
Indiana			X		X								X
Minnesota[3]			X		X		X		X				X
New Hampshire			X				X						
Group 3													
California				X				X		X		X	X
Illinois		X						X					
Maine			X				X			X			X
Maryland			X					X		X	X		X
Massachusetts			X				X				X		X
Ohio			X		X		X	X	X				
Group 4													
Colorado	X						X				X		X
Michigan			X			X	X	X	X	X	X	X	X
Washington	X						X		X				X
Group 6													
District of Columbia		X					X				X		X
Oregon	X						X						
Pennsylvania			X					X	X				
Rhode Island	X						X						X

[1] New York - This state also meets Group 3 characteristics

[2] Wisconsin - This state also meets Group 2 & 3 characteristics

[3] Minnesota - This state also meets Group 3 characteristics

Agency did not give the HMO an opportunity to participate in marketing. In ten percent of the States, the HMO was responsible for the majority of the marketing. In these cases, the State Medicaid Agency either helps in a limited fashion by efforts such as sending out booklets the HMO has given them, or does not help at all. The HMO that does not receive any support from the State would like to see the State Medicaid Agency take more of an interest in the marketing effort.

Table 2 displayed the Medicaid enrollment and the degree of marketing effort in the interviewed States. Although the most common marketing approach is the cooperative marketing effort between the State MA and the HMO, there does not appear to be any real difference in HMO/Medicaid enrollment due to the type of marketing approach practiced. Therefore, no strong relationship is seen between Medicaid enrollment and the party that does the majority of the marketing.

Marketing tools identified by the HMOs and State Medicaid Agencies used most frequently were:

- Brochures or enrollment packets; and
- Mass mailings.

The most common marketing tool was the use of brochures or enrollment packets. The brochures or packets which explained the HMO option were given to new eligibles at the enrollment office and were also mailed to existing eligibles. The packets usually contained a response card which the individual would fill out if they were interested and the HMO would then send them more information or would often visit the individual in person.

Mass mailings are another common method of marketing the HMO option. Usually, when HMOs are interested in mass mailings, they will inform the State Medicaid Agency of the area where they would like their marketing materials sent (i.e. a certain zip code area). The State MA will then do the mailings for the HMO in the designated area if the HMO provides all the materials and pays for the mailing.

Also, marketing is done at the County Office when Medicaid eligibility is county determined. Some MAs have a videotape or slide presentation of the HMO option which is presented to new Medicaid eligibles. These same State MAs often have a representative available at the County Office to answer any questions from the presentation and to explain the difference between the HMO and State fee-for-service coverage.

Some HMOs conduct door-to-door marketing. Since HMOs can not get the names of Medicaid eligibles from the State, they often market in areas where they know there is a high concentration of Medicaid eligibles. HMOs can also conduct door-to-door marketing when the interested eligible has signed a response card requesting information from the HMO on their program. This was found to be an effective means of enrolling Medicaid recipients but it was also found to be very expensive and time-consuming.

A few State MAs and HMOs advertise the HMO option through various mediums. Radio and newspaper advertisements appear to be the most commom method. State MAs also make use of public events such as community meetings and health fairs to bring attention to the HMO program.

A wider variety of marketing tools appear to be used when the State Medicaid Agency and the HMO participate jointly in the marketing effort. When the State MA and the HMO can concentrate on different marketing efforts, they use various marketing tools and therefore are able to reach a wider range of Medicaid eligibles.

The States with OBRA legislation that have HMO/Medicaid contracts appear to have a more cooperative marketing approach than States that do not have OBRA legislation. However, both groups use the same proportion of marketing tools and perceive approximately the same amount of marketing barriers.

HMOs' Perceptions. Approximately sixty percent of the HMOs saw marketing as a problem in their contracting. A few HMOs cited this as a problem since their HMO enrollment office was not located in or near the County Office and if the eligible was interested they would have to make their own arrangements to go over to the HMO office. Some HMOs cited their lack of access to enrollees as a problem since they do not receive a listing of Medicaid eligibles in their service area causing them to do mass mailings or door-to-door marketing which is very expensive. One HMO had a problem because the State MA wanted to take over the marketing efforts and the HMO felt this would not be as effective as their current cooperative effort.

Medicaid Agencies' Perceptions. Only ten percent of the State MAs surveyed perceived marketing to be a barrier in HMO/Medicaid contracting. In general, marketing strategies they had undertaken had proved to be unsucessful in enrolling a significant number of enrollees.

There was no relationship between who did the marketing (i.e., State MA, HMO, or State MA/HMO) and the barriers perceived. Approximately half of each group cited various problems in their marketing effort.

C. MEDICAID ENROLLMENT IN HMOs

Table 9 illustrates Medicaid enrollment in HMOs from 1981 to present and compares enrollment to the geographic area served, the eligibility group served and the enrollment option.

The majority of the States (approximately 70%) began their initial HMO/Medicaid contracts in the 1970s. Twenty-five percent of the States began contracting in this decade and five percent began in the 1960s.

The Table illustrates the actual enrollment numbers from 1981 to 1985 as well as the percentage change in the enrollment from the previous year. As these figures were given by the State MAs, some of the State MA enrollment numbers are more complete than others.

Looking at the year 1984, a year where most State Medicaid Agencies had enrollment data available, approximatley 40% of the State MAs stated they had an increase in their HMO enrollment from the previous year while approximately 20% had a decrease in their 1984 enrollment. It could not be determined from the remainder of the Medicaid Agencies whether their enrollment increased or decreased as there was not enough data.

Comparing the enrollment number to the geographic area served, eligibility group served and enrollment options, a relationship between an increase or a decrease in the Medicaid enrollment does not appear to exist. As stated in a previous section, HMOs generally serve more than one county, serve the AFDC population, and have voluntary enrollment. However, having all of these options does not ensure that the HMOs enrollment will increase from one year to the next. There is not any State grouping, or any certain options that seem to help the HMO and Medicaid Agency experience a more effective enrollment. Nor does there appear to be any relationship between the presence of OBRA legislation and the size of Medicaid enrollment in HMOs.

D. BARRIERS TO MEDICAID/HMO CONTRACTING

1. Barriers to Current Contracting

Many parties benefit from the HMO/Medicaid contract--the Medicaid recipients are able to receive various preventive services as well as continuity of care, the providers have financial incentives to care for the Medicaid population, and the State Medicaid Agency can achieve cost savings from this program.

HMOs' Perceptions. Although there are many benefits from HMO/Medicaid contracting, the surveyed HMOs and MA's did cite various barriers and/or problems on their current contracts. The

TABLE 9
MEDICAID ENROLLMENT IN HMOs

GROUPS STATE	Initial Contract Date	1981		1982		1983		1984		1985		Geographic Area Served	Eligibility Group Served	Enrollment Options
		Actual	% Change	Actual	% Change	Actual	% Change	Actual	% Change	Actual	% Change			
Group 1														
New York[1]	?									50	-	2	-	1
Utah	1977	5,278	-	7,088	34.2%	6,911	(-2.5%)	6,806	(-1.5%)			2	3	1
Wisconsin[2]	1984									101,796		2	1	2
Group 2														
Connecticut	1983					229	-	375	63.7%	391	4.2%	1	1	1
Indiana	1983					4,179	-	3,021	(-27.7%)			2	1	1
Minnesota[3]	1977			225	-	3,500	1,455%	6,000	71%	6,600	10%	2	1	1
New Hampshire	1983					508	-	529	4.1%			2	4	1
Group 3														
California	1970's							198,379	-			2	3	1
Illinois	1976	3,268	-	6,589	100%	35,375	436%	56,114	59%			1	1	1
Maine	1984							444				1	1	1
Maryland	1975	23,420	-	16,788	(-28.3%)	15,382	(-8.3%)	14,575	(-5.2%)	15,106	3.6%	2	3	1
Massachusetts	1971							4,159	-	4,293	3.2%	2	4	1
Ohio	1978			7,900	-	9,200	16.4%	19,200	108%	20,000	4.1%	2	1	1
Group 4														
Colorado	1974							5,580	-			2	3	1
Michigan	1972	64,234	-	73,760	14.8%	85,853	16.4%	92,181	7.3%			2	3	1
Washington	1960's			6,150	-	5,660	(-8%)	5,430	(-4%)	5,350	(-1.5%)	2	1	1
Group 6														
District of Columbia	1972							142	-			1	1	1
Oregon	1978									10,000	-	2	1	2
Pennsylvania	1970's	1,560	-	2,780	78%	5,180	86%	8,000	54%	12,800	60%	2	3	1
Rhode Island	1972	165	-	251	52%	268	6.7%	285	6.3%			3	4	1

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 & 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

CODE:

Geographic Area Served
1. One County
2. Multiple Counties
3. State

Eligibility Group Served
1. AFDC
2. AFDC & SSI
3. All Groups
4. AFDC & Other

Enrollment Options
1. Voluntary
2. Forced Choice
3. Mandatory

surveyed HMOs experienced almost double the amount of barriers and/or problems to contracting than their respective State Medicaid Agency did. The citing of more barriers/problems by HMOs than the State Medicaid Agencies was seen both in the barriers cited as well as the group the State was in. It is also interesting to note that those areas where the HMOs saw the greatest barriers and/or problems in contracting, the State MAs saw the least barriers and/or problems. No group cited more or less barriers than other groups. Table 10 displays the most identified problems which were:

- Turnover of Medicaid eligibles;
- Eligibility determination;
- Marketing;
- Reimbursement rates; and
- Administrative burden.

The most common problem experienced by the HMOs was the turnover of Medicaid enrollees. This was often linked to the absence of any extended eligibility, problems in timely and accurate eligibility determination, and marketing access problems. These four problems were often the source of most of the frustration in contracting with the State Medicaid Agency. Some State MAs were trying to help relieve these barriers by: updating and/or improving their eligibility information system in order to increase its availability and accuracy, developing a more cooperative marketing approach with the HMO in order to increase the base enrollment, and looking into the possibilities of implementing an extended eligibility provision for Federally qualified HMOs.

Rates were also a source of problems for HMOs. The HMOs cited rates as a barrier to contracting for various reasons such as: they had little to no input into the reimbursement rate, rates were outdated and inadequate, there were problems with the timeliness of the rate increases and the rate adjustments, and their reimbursement rates were barely covering costs. It is interesting to note here that when the HMOs stated they had a problem with the rates, only 10% of the HMO's corresponding Medicaid Agency also cited rates to be a problem.

The administrative burden of serving this population was also stated as a problem for HMOs as the HMOs felt that there were more administrative costs per Medicaid enrollee in terms of eligibility determination, reporting requirements and contracting as compared with the private sector.

TABLE 10

BARRIERS
TO CURRENT CONTRACTING

GROUP STATE	BARRIERS PERCEIVED BY STATE											BARRIERS PERCEIVED BY HMOs										
	Marketing	Eligibility Determination	Turnover	Reporting Requirements	Contracting	Payment	Admin. Burden	75% Rule	Stigma	Rates	Other	Marketing	Eligibility Determination	Turnover	Reporting Requirements	Contracting	Payment	Admin. Burden	75% Rule	Stigma	Rates	Other
Group 1																						
New York[1]					X			X			X											
Utah									X	X		X										
Wisconsin[2]								X			X		X	X	X	X		X			X	X
Group 2																						
Connecticut									X		X											
Indiana			X								X	X		X			X				X	X
Minnesota[3]											X	X			X	X	X	X			X	
New Hampshire					X								X	X		X						X
Group 3																						
California	X				X			X		X	X	X	X	X	X	X	X	X	X	X	X	
Illinois								X						X		X					X	X
Maine				X	X							X	X	X				X				X
Maryland								X		X		X										
Massachusetts					X				X		X	X	X	X								
Ohio								X			X		X	X			X				X	
Group 4																						
Colorado		X									X	X	X					X				
Michigan	X							X				X	X	X			X		X	X	X	X
Washington									X	X		X	X	X			X	X			X	
Group 6																						
District of Columbia																	X	X				
Oregon											X			X							X	
Pennsylvania									X		X		X	X								
Rhode Island											X	X	X								X	

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

Even though the HMOs usually cited more than one barrier and/or problem in their Medicaid contract it appeared that these were problems that could be worked out, or at best lived with, and that the HMOs would continue to contract with the State Medicaid Agency. Very few HMOs cited their problems such that it made it impossible to continue to contract. HMOs are fairly committed to serving this population and are willing to have a few problems in their contracting rather than choosing not to at all.

Medicaid Agencies' Perceptions. The State Medicaid Agencies perceived fewer barriers to contracting than did the HMOs. Table 10 displays problems identified which include:

- The 75% Rule;
- Stigma of serving the Medicaid population; and
- Contracting.

The most common problem that the State MAs cited was in regard to the 75% rule. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicaid and Medicare recipients account for no more than 75% of the HMO's total enrollment. This barrier was fairly easy to overcome by the HMOs and the State MAs. Most of the HMOs with this enrollment-mix problem had a waiver or were applying for a waiver. However, the long-term implications of waiver renewals is unknown.

Another problem that the State MAs saw as a barrier to their contracting with HMOs was the perception that HMOs had about the Medicaid population. The State MAs said that the HMOs felt that Medicaid enrollees were sicker than the rest of the population and if they provided care to Medicaid enrollees, it would not be cost-effective for them. Some State MAs tried to defend their position that this was not true by giving data to HMOs that Medicaid eligibles do not cost more than the general public but this was not always successful.

The State Medicaid Agencies also saw contracting as a problem for them. Some State M.A's have had trouble with the contracting process because they had no prior experience with contracting and they were learning "as they went."

State MAs also had many State-specific barriers to contracting. These comments were varied and ranged from complaints of regulation and licensing of health care plans being too expensive and time consuming for them, to the Federal capitation rate being a barrier.

Comparing the barriers to contracting with the States that have OBRA legislation to the States without OBRA legislation, there does not seem to be any strong relationship. The State MAs that contract without OBRA legislation did not cite as many barriers to contracting as the State Medicaid Agencies with OBRA legislation did, but the HMOs in both groups cited approximately the same amount of barriers.

2. The 75% Rule

Federal regulations specify various rules and requirements that must be met in order for a HMO to be eligible to enter into a HMO/Medicaid contract with the State Medicaid Agency for the enrollment of Medicaid eligibles. One such requirement is in regard to the composition of the enrollment in the HMO. The regulation from TEFRA 1982 states that the total number of Medicaid and Medicare beneficiaries may be no more than seventy-five percent of a prepaid health plans' membership (i.e. a HMO) or 75% of a case management system's revenues. If HMOs can not meet this enrollment mix, there are a few measures that the HMO can take in order to enter into a HMO/Medicaid contract. HMOs can open up new health delivery sites in order to increase the enrollment mix, or they can apply for a waiver. If the waiver request is approved, the seventy five percent composition of enrollment requirement may be waived for a period of up to three years.

HMOs' Perceptions. Two HMOs stated that they had a problem with the 75% rule. One HMO currently has a waiver as they serve about 90% Medicaid clients. They feel their problem to be that if they start serving more private clients to increase the enrollment mix, they will be serving fewer Medicaid clients and serving this population is one of their major committments. The other HMO forsees that they will always have a problem with this requirement and so they have opened up some new service sites and are also expanding a mixed model arrangement in order to solve this 25-75% mix dilemma.

Medicaid Agencies' Perceptions. As seen in Table 11, forty percent of the State MAs stated that they have current and/or future problems with HMOs meeting the 75% rule. The twenty State MAs surveyed had a total of seventy nine HMO/Medicaid contracts. Out of these contracts, approximately twenty percent of the HMOs had a problem with this enrollment composition requirement. The majority of the HMOs obtained a waiver for this enrollment regulation while one HMO opened two new sites in order to meet the enrollment mix. There are also some HMOs that are interested in contracting with the State Medicaid Agency and have applied for a 75% rule waiver.

TABLE 11

75% RULE

GROUP STATE	Number of HMOs in State	Current and/or Future Problems with HMOs meeting 75% Rule	# of HMOs with Problems		Actions Taken to Solve Problems				Barriers to 75% Rule	
			Actual	Estimate	Have Waiver	Applied for Waiver	Opened New Sites	Other	Perceived by State	Perceived by HMO
Group 1										
New York[1]	2	X		2					X	N/A
Utah	1									
Wisconsin[2]	13	X	3		X				X	
Group 2										
Connecticut	1									N/A
Indiana	2									
Minnesota[3]	8	X	1		X					
New Hampshire	1									
Group 3										
California	12	X	1		X				X	X
Illinois	6	X		2	X				X	
Maine	1									
Maryland	5	X	3		X				X	
Massachusetts	6									
Ohio	3	X	1		X				X	
Group 4										
Colorado	3									
Michigan	7	X		3			X			X
Washington	3									
Group 6										
District of Columbia	1									
Oregon	1									
Pennsylvania	3									
Rhode Island	1									

[1] New York - This State also meets Group 3 Characteristics

[2] Wisconsin - This State also meets Group 2 & 3 Characteristics

[3] Minnesota - This State also meets Group 3 Characteristics

Approximately seven State MAs felt this 75% rule to be a problem in their contracting. These State MAs either have HMOs that have current problems meeting the enrollment mix or they anticipate that other HMOs interested in contracting in the future will have a problem.

The State Medicaid Agencies with OBRA legislation cited more problems in meeting the 75% rule and perceived more barriers with this rule than did the State MAs that contract without OBRA legislation. The Medicaid Agencies with OBRA legislation did however, have more HMO contracts than their counterparts did.

3. HMOs/States Medicaid Agencies That Do Not Contract

States with and without OBRA legislation that do not have any HMO/Medicaid contracts were interviewed as well as one HMO in each of the corresponding ten States. Their comments are seen on Table 12.

Group 5 HMOs' Perceptions. HMOs in these States were interviewed and were asked if they had any current and/or future plans for HMO/Medicaid contracting and what their main reasons for not contracting with the State Medicaid Agency were. Three out of the four HMOs stated that they had future plans to contract with the State Medicaid Agency and would certainly consider contracting if the State MA approached them about the possibilities of contracting. In the one State where the HMO and State MA see no future contracts being established, the political environment is such that HMO/Medicaid contracts are not being pushed since other programs are being planned, developed and implemented. It was also asked of the HMOs if they would like to incorporate the OBRA legislation into their contract, if they decided to contract with the State Medicaid Agency and three of the HMOs stated that they were unsure if they would want to use the OBRA legislation.

Group 5 Medicaid Agencies' Perceptions. The four State MAs in Group 5--States with OBRA 1981 legislation but have no contracts with HMOs were asked similar questions. Again, three out of the four State MAs (in the same three States) said that they had future HMO contracting plans. They all had various reasons for not having any current contracts such as a poor geographical distribution of HMOs, unacceptable HMO proposals and, concentration of efforts on current programs.

Group 7 HMOs' Perceptions. The other Group that was interviewed was the six HMOs and State MAs that did not have OBRA 1981 legislation and did not have any HMO contracts. Only one HMO in Group 7 was planning to contract with the State Medicaid Agency in the near future. The HMO had been concentrating their current efforts on the private sector and

TABLE 12

STATES/HMOs THAT DO NOT CONTRACT

GROUP STATE	State Medicaid Agency has current and/or future plans for HMO contracting	State Medicaid Agency's main reasons for not contracting	HMO has current and/or future plans for Medicaid/HMO contracting	HMO's main reasons for not contracting
Group 5				
Kansas	·Future plans to contract	·Proposed HMO contracts have not been acceptable to state	·Future plans to contract	·HMO did not feel prepared to contract
Kentucky	·No current/future plans to contract	·HMOs contracting requirements are unacceptable	·No current or future plans to contract	·Feel that State Medicaid office is not willing to contract
Nevada	·Future plans to contract	·Only HMOs are in Reno & Las Vegas ·Concentrating on case mgmt.	·Future plans to contract	·Concentrating current efforts on the Medicare contract
Tennessee	·Future plans to contract	·HMOs have not been interested ·Waiting to learn from current programs	·Future plans to contract	·HMO was at capacity but can now handle clients
Group 7				
Georgia	·Current plans to contract	·Had been unable to get county specific utilization data until last year	·Future plans to contract	·Concentrating current efforts on their private sector and Medicare clients
Iowa	·Future plans to contract	·Concentrating on hospital capitation issues ·HMOs not near Medicaid population	·No current/future plans	·Concentrating efforts on private sector and Medicare clients ·Unfamiliar with Medicaid population
N. Carolina	·Future plans to contract	·Past PHP/HMO contract negotiations failed	·No current/future plans to contract	·Do not contract with public sector
Oklahoma	·No current/future plans	·Feel that HMO contracting doesn't work with Medicaid population	·No current/future plans	·Do not contract with public sector
Texas	·Possible future plans	·Have effective HIO program ·Starting HMO/Medicaid demonstration program	·No current/future plans	·Concentrating efforts on Medicare contract
Virginia	·No current/future plans	·Feel that HMOs don't provide level of care that the State desires	·No current/future plans	·Concentrating efforts on current federal contracts (Medicare and OPM)

Medicare clients but since the State Medicaid Agency had been expressing an interest in contracting, they feel a mutual agreement will be worked out. The rest of the five HMOs interviewed had no current and/or future plans to contract. Two of the five HMOs said that it was in their operational philosophy that they do not contract with the public sector, while the other three HMOs are still concentrating their enrollment efforts on other populations. The latter three HMOs, however, did state that if the State Medicaid Agency approached them about the possibilities of contracting, they would consider the offer.

Group 7 Medicaid Agencies' Perceptions. Three State MAs said that they had current and/or future plans to contract with HMOs. One State MA has possible plans for contracting depending upon the results they receive from a HMO/Medicaid demonstration project that is being undertaken. Two State MAs have no plans to contract with any HMOs in the future because they feel that HMO/Medicaid contracting is ineffective and that HMOs do not provide the level of care that the State MA feels should be delivered to the Medicaid population.

E. CURRENT MEDICAID HMO ENROLLMENT

1. HMOs' Perception of Influencing Factors

State Medicaid Agencies have various reasons for establishing HMO/Medicaid contracts, but they generally believe that HMOs have some advantages over the State fee-for-service program. The major reason that State MAs initiate contracting is because they feel that the contract will result in cost savings for the State. State MAs felt that these eligibles were often receiving excessive and unnecessary care under the State fee-for-service program and that an HMO would offer to Medicaid eligibles appropriate levels of quality care in an appropriate health care delivery setting.

When HMOs were queried as to why they contracted with Medicaid Agencies and what they felt attributed to the current enrollment status in their HMO (see Table 13), the factors most frequently identified were:

- Commitment to serve the Medicaid population;
- Provision of quality health care services;
- Reputation of the HMO; and
- Good marketing.

The HMOs' commitment in serving the Medicaid population was the most common factor for the HMOs' current status of Medicaid

TABLE 13

FACTORS LEADING TO CURRENT MEDICAID HMO ENROLLMENT

GROUP STATE		FOC Waiver	Extended Eligibility	Commitment by HMO	Marketing Good	Marketing a Problem	Provide Quality Services	Good Reputation	Established HMO	Low Turnover	State has rich Benefit Package	Members Pleased	Providers Endorse HMO	Providers do not Endorse HMO	State/County Endorse HMO	Other demo- Programs in State	Good Location	Enrollment Base	Dual Choice in State	Anonymity in HMO Plan
		FACTORS																		
Group 1																				
New York[1]	N/A																			
Utah							X													
Wisconsin[2]		X		X					X											
Group 2																				
Connecticut	N/A																			
Indiana						X					X									
Minnesota[3]			X																	X
New Hampshire										X		X								
Group 3																				
California				X	X			X	X										X	
Illinois				X																
Maine													X							
Maryland							X										X			
Massachusetts				X																
Ohio				X																
Group 4																				
Colorado													X		X					
Michigan					X		X			X						X		X		
Washington			X					X						X						
Group 6																				
District of Columbia			X																	
Oregon		X						X												
Pennsylvania					X												X			
Rhode Island				X																

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[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

enrollment. Many HMOs stated that they started with a strong commitment to provide services to this population and that this continuing commitment was the reason why they have their present level of enrollment.

HMOs also stated that the commitment of other parties involved in contracting affects the Medicaid enrollment. HMOs that had the endorsement of the HMO plan by their area physicians as well as by the State and/or County Office had an easier time enrolling Medicaid eligibles into their program. HMOs that did not have the support of these parties had a more difficult time enrolling Medicaid eligibles. For example, in one State the HMOs felt that the State MA was encouraging and giving more publicity to other State demonstration programs and the HMO felt that they would have had a higher Medicaid enrollment, if not for the State support and existence of these other programs.

Another positive factor cited by the HMOs was that they provided quality health care services to their HMO population and that the Medicaid recipients realized the quality care they were receiving. The reputation of the HMO was also mentioned by some HMOs as a factor. If an HMO had a well-known reputation they found that Medicaid eligibles were more likely to enroll in the HMO and that marketing efforts were not always as difficult since the eligibles had heard of the HMO before.

The presence and/or absence of extended eligibility was also stated as a factor. One State MA that had this provision felt that it gave an added incentive to eligibles to enroll. Another State, Minnesota, will be dropping this provision as of July 1985 due to problems encountered by the State Medicaid Agency. In two other States with the provision, the HMOs did not cite this as either a positive or negative factor. Generally the HMOs that did not have this provision regarded it as an asset and thought that it would help increase as well as retain Medicaid enrollment. Three additional State Medicaid Agencies, D.C., New York, and Massachusetts, are currently planning to implement this provision.

Marketing was mentioned as a positive factor by some HMOs and as a negative factor by other HMOs. Generally when the HMOs participated in the marketing effort they felt it had a very positive impact on Medicaid enrollment. In those States where Medicaid enrollees had to make an extra effort to enroll in the HMO because the HMO enrollment office was not located in the county office, marketing was seen as a negative factor.

In one State, Wisconsin, the HMOs cited the Section 2175 waiver as having a positive impact on their current Medicaid enrollment. It should be noted that this waiver was used to make HMOs a forced choice for Medicaid recipients in both Dane and

TABLE 13

RESULTS

GROUP STATE	ENROLLMENT				COST SAVINGS				QUALITY OF CARE					ACCESS				
	Increased	Decreased	No Change	No Results Yet	Increased	Decreased	No Change	No Results Yet	Improved	Good	Comparable to State FFS Program	Poor	No Results Yet	Improved	Good	Comparable to State FFS Program	Poor	No Results Yet
Group 1																		
New York[1]				X				X										
Utah	X				X										X			
Wisconsin[2]	X				X								X		X			
Group 2																		
Connecticut	X				X					X							X	
Indiana				X				X					X					X
Minnesota[3]	X						X				X				X			
New Hampshire			X		X					X					X			
Group 3																		
California	X					X			X					X				
Illinois	X				X								X					X
Maine				X				X					X					X
Maryland	X				X						X				X			
Massachusetts	X				X					X				X				
Ohio	X				X					X				X				
Group 4																		
Colorado			X		X								X		X			
Michigan	X				X					X					X			
Washington		X					X				X					X		
Group 6																		
District of Columbia		X			X					X					X			
Oregon	X				X					X					X			
Pennsylvania	X				X					X					X			
Rhode Island			X			X				X					X			

[1] New York - This State also meets Group 3 characteristics

[2] Wisconsin - This State also meets Group 2 and 3 characteristics

[3] Minnesota - This State also meets Group 3 characteristics

Milwaukee Counties and therefore necessarily increased Medicaid enrollment.

2. Medicaid Agencies' Perceptions

In an effort to fight the increasing costs of the Medicaid program, State Medicaid Agencies have entered into HMO/Medicaid contracts as a way to a more cost-effective Medicaid program, while at the same time ensuring that the Medicaid population was receiving quality health care services.

The twenty State MAs that contracted with HMOs were interviewed as to the results of their contracting efforts in terms of their enrollment, cost savings, quality of care, and access to health care in the Medicaid/HMO contract. Table 14 displays the results.

Enrollment. Seventy percent of the Medicaid Agencies have experienced an increase in enrollment in the HMO program over the two most recent years for which data were available (1983-84 or 1984-85), 20 percent experienced a decrease in enrollment, and data were not available for two States. The decrease in two States, Utah and Washington, was inconsequential (1.5%). The decrease in Indiana (27.7%) was attributed by one HMO to marketing problems. Group 3 (States that contract with State-qualified HMOs) had the largest percentage of State MAs reporting an increase in enrollment.

When actual enrollment figures[1] are examined for 1983 compared to the most current year enrollment figures available, Medicaid enrollment in HMOs has increased from 176,404 to 324,385--an increase of 84 percent. If these enrollment figures are examined in terms of States using OBRA legislation (Groups 1,2,3) versus States not using OBRA legislation (Groups 4,6), States using OBRA legislation had an increase in enrollment of 169 percent compared to 14 percent for States not using OBRA legislation. Thus, while States using OBRA legislation and States not using OBRA legislation had approximately the same enrollment figures in 1983 (79,443 to 96,961), the States using OBRA legislation increased their enrollment ten times more than the group of States not using OBRA legislation. However, it should be noted that Wisconsin's mandatory choice for Dane and Milwaukee counties added over 100,000 enrollees from 1983 to 1985 and was the major contributor to the increase.

Cost Savings. In terms of cost savings, 65 percent of the State MAs felt that the Medicaid Agency had experienced cost savings from their HMO/Medicaid contracts. However, few State

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[1] Data are not available for CA, CO, DC, NY, or OR.

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MAs could give specific dollar amounts and when a dollar amount was given it was frequently the difference between FFS and the HMO capitation amount. Twenty percent of the State MAs reported no cost savings and 15 percent of the State MAs said they had no basis for an assessment of cost savings at this point.

Sixty-two percent of the Medicaid Agencies that had implemented OBRA 81 legislation perceived that they had HMO/Medicaid contracting cost savings while seventy-one percent of the State MAs that had not implemented OBRA 81 legislation perceived that their contracting resulted in cost savings to the State Medicaid Agency.

Most State MAs have not conducted evaluations to assess the cost effects of their HMO/Medicaid contracting. Six Medicaid Agencies did give an estimate of their savings. These estimates were quoted in various units and are not readily comparable. Frequently when State MAs talked about cost savings they equated savings with a percent of FFS. If this percent of FFS was less than 100 then the State MA frequently perceived there were cost savings. Obviously this could be an indication of savings but it is not conclusive evidence. In addition to such factors as stop-loss agreements, reinsurance, and benefits reimbursed outside of the HMO contract, it is also possible that adverse/favorable selection of enrollees is a factor.

HMOs in States that recently began contracting voiced concern regarding being ratcheted down. For example, this year the HMO would be given 95 percent FFS which the HMO finds financially feasible. However, next year after the HMO had made the resource commitment to serve the Medicaid population, the State would only negotiate at 90 percent FFS and this might not be financially feasible for the HMO. This concern could be somewhat unfounded based on the experience of two States with contracting histories back to the early seventies--California and Rhode Island. These States report basically no savings--the margin between FFS and HMO rates has become increasingly smaller rather than larger.

Quality of Care. One of the goals of the health care delivered in the HMO/Medicaid contracts is that the quality of care in the HMOs meets or exceeds the minimal acceptable standards of care and practice in the fee-for-service Medicaid program. Many State MAs use quality assurance audits as part of their monitoring process in an effort to actively promote quality of care and to identify and eliminate deficiencies that may exist.

The majority of the Medicaid Agencies reported that quality of care under HMO/Medicaid contracting was at least as good as the care provided under the fee-for-service Medicaid program. California reported that the quality of care under their

HMO/Medicaid contract had improved because of medical audits. Several other State MAs based their assessment of quality of care being "good" on their medical audits. Seven State MAs reported no results yet regarding the quality of care delivered under HMO/Medicaid contracts. Two of those seven Medicaid Agencies were conducting studies, one was developing a monitoring system, and four had no comment.

Most States that had implemented OBRA legislation as well as most States that had not implemented OBRA legislation reported that the quality of care rendered as a result of HMO/Medicaid contracting was at least as good as care rendered under FFS.

Access to Health Care. Medicaid Agencies also have requirements in terms of the access to health care services that will be provided to the Medicaid enrollees in HMOs. State MAs must assure that the services provided by an HMO are as accessible to Medicaid enrollees (in terms of timeliness, amount, duration, and scope) as services are to non-enrolled Medicaid recipients within the area served by the HMO.

Delivery sites must usually be located within reasonable proximity to the served clients in order that they can gain fairly easy access to the site. HMOs must also ensure the State MAs that there are adequate staff resources to provide quality services to those receiving care. Appointment schedules must be such that they have appropriate procedures for handling emergency, non-emergency and walk-in clients as well as arrangements for providing adequate after-hours coverage.

The majority of the Medicaid Agencies felt that the access to their HMOs was good. Only two State MAs did not feel that access was at least as good as access under FFS. Those two State Medicaid Agencies, Massachusetts and Connecticut, stated that the HMOs were not located in areas populated by a lot of Medicaid recipients. Massachusetts has recently tried to remedy this by contracting with more HMOs and feels that the situation is improving. Connecticut contracts with one HMO and reported that it takes about two bus transfers for Medicaid enrollees to get to the HMO site and is therefore inconvenient.

The majority of Medicaid Agencies with OBRA legislation as well as the majority of State MAs with no OBRA legislation report that access is good. Four State MAs report no results yet regarding access to care and those four State MAs all have OBRA legislation. Their lack of information on results is a result of fairly recent implementation of contracting activity.

F. UPDATE ON IMPLEMENTATION OF OBRA

September was selected as the cut-off date for the grouping status of the States. From September 1984 to June 1985 (last contact with the State), several of the States surveyed had made changes in the legislative authorities that they use or do not use. Those States and the changes they made are as follows:

- District of Columbia - D.C. now provides extended eligibility benefits for categorically needy and medically needy recipients who are enrolled in a Federally-qualified HMO and who become ineligible for Medicaid for a period of six months.
- New York - Their Section 2175 Waiver has terminated and they are in the process of applying for the extended eligibility process.
- Massachusetts - In April 1985, the State planned to offer to categorically needy recipients the six-month eligibility provision.
- Minnesota - Their extended eligibility provision was to be stopped as of July 1, 1985.
- Oregon - As of February 1985, the Section 2175 waiver was implemented and incorporated the use of an HMO.
- Virginia - This State has recently implemented the Section 2175 waiver but does not incorporate the waiver into the use of an HMO and continues not to contract with HMOs.

Thus, it appears that States are continuing to add and/or delete OBRA legislation that they incorporate into their Medicaid programs. The directions and results of the use of that OBRA legislation appears mixed.

CHAPTER SIX
CONCLUSIONS AND FUTURE IMPLICATIONS

A. STUDY FINDINGS

This study was initially designed to examine seven groups of Medicaid Agencies and HMOs, five groups of States that had implemented OBRA legislative authorities and two groups of States that had not implemented OBRA legislative authorities. The detailed tables and analyses address these groups. However, in the final analysis there appear to be few differences in the responses among the groups or even between State Medicaid Agencies/HMOs using OBRA legislative authorities and those not using OBRA legislative authorities. Thus, most of our findings relate to Medicaid/HMO contracting in general. Out of the forty-eight continental States and the District of Columbia, only fourteen States had used OBRA legislative authorities in conjunction with HMO/Medicaid contracting. Three State Medicaid Agencies used the 2175 waiver with HMO contracting, five had extended eligibility, and nine contracted with State-qualified HMOs.[1]

1. Descriptive Characteristics

Thirty State Medicaid Agencies and at least one HMO in each of those States were surveyed. The States were divided into two basic groupings--those States where the State Medicaid Agency uses OBRA 1981 legislative authority and those States where the State Medicaid Agency does not use OBRA 1981 legislative authority. The table below describes the most common characteristics found of HMO/Medicaid Agency contracting among the thirty States and breaks out the activities according to whether the States have or do not have OBRA legislation. The table shows essentially the same results as those States with OBRA or no OBRA legislation:

HMO/Medicaid Character'stics	%Total States (n=30)	% with OBRA (n=20)	% with no OBRA (n=10)
HMOs serve multiple counties	75	75	71
HMOs serve AFDC only	50	58	43
Enrollment in HMO is voluntary	85	85	86
Marketing is HMO/Medicaid cooperative effort	65	85	29
Rates negotiated or set by State	90	85	100

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[1] Two States used more than one of the three legislative authorities.

Marketing in the States with no implementation of OBRA legislative authorities has been done primarily by the State Medicaid Agency only rather than in conjunction with HMOs as in the OBRA States.

2. Processes

Six major processes used by the twenty contracting HMOs and State Medicaid Agencies were examined. The six processes and the results show the following:

Eligibility - Medicaid provides medical assistance to groups of people who qualify under one of the cash assistance programs of the Social Security Act or who qualify as medically needy. In contracting with HMOs, State Medicaid Agencies most frequently choose to contract only for services to the enrollees who qualify under the Families with Dependent Children (AFDC) program. This results in HMOs providing services for the group of Medicaid eligibles that are generally more healthy than other groups. The procedures for informing the HMO of the Medicaid member's eligibility vary between the State Medicaid Agencies, but there are generally two ways that members enroll and are determinined eligible. One way is that the Medicaid eligible enrolls in the HMO, which then verifies eligibility with the State Medicaid Agency. The second way is that the individual enrolls at the Medicaid eligibility office, which then notifies the HMO of the member's enrollment and eligibilty. The time period varies among Medicaid Agencies as to how often the HMOs are updated on Medicaid eligibles. Only three States (HMOs/Medicaid Agencies) stated that there was a significant time lag between HMO enrollment and the time when the recipient could use HMO services.

Benefits - HMOs are required to make their services available to Medicaid enrollees to the same extent Medicaid Services are available from other sources to nonenrolled Medicaid recipients in the area. Forty percent of the HMOs offered more services (i.e. health education and promotion classes) than the complete Medicaid benefit package and 35 percent offered the same package. Services not provided by HMOs were covered with fee-for-service (FFS) in 86 percent of the cases, and either contracted by the HMO or by the State Medicaid Agency in the remainder of the cases.

Reimbursement - Capitation rates ranged from $13.52 to $285.80 per month per recipient. This broad reimbursement range can be attributed to the fact that HMO/Medicaid contracts cover different eligibility groups and contracts include different services depending on the services in the State Medicaid Program benefit package and the services which the HMO contracts to provide. In order to accommodate these variations when State Medicaid Agencies and HMOs were negotiating/setting capitation rates, various factors were used including: eligibility group, geographic location, age, and sex. In almost all States, capitation rates were either negotiated between the HMOs and the State or set by the State. In approximately three-fourths of the States, rates were based on FFS and used eligibility groupings and geographic groupings to determine the rates. Full risk was assumed by 75 percent of the HMOs, stop-loss agreements were in 60 percent of the contracts, State provided reinsurance was provided in only six out of 20 States, and dummy claims were submitted by HMOs in only four States.

Contract Development - Approximately 60 percent of the contracts used by the HMOs and State Medicaid Agencies were based on a standard State model developed by each State. Contracting was initiated more successfully when the political environment within the State encouraged contracting. In over 50 percent of the HMO/State Medicaid Agency contracts, the impetus to contracting was given by the State Medicaid Agency, State legislature, or combined State/HMO. In 25 percent of the States, the HMO was responsible for initiating the contracting process and in the remaining 25 percent, an outside influence (i.e. national study) was responsible.

Contract Monitoring - State Medicaid Agencies usually limit their monitoring activities to reporting requirements and on-site visits/audits. Ninety-five percent of the State Medicaid Agencies have reporting requirements for the HMOs with 95% of the agencies also conducting site visits.

Marketing - The most common marketing approach in the States was a cooperative effort between the State Medicaid Agency and the HMO. Marketing tools most used by HMOs/Medicaid Agencies were brochures (used by 75%) and mass mailings (used by 40%).

3. Barriers

While there were no significant differences in the barriers to HMO/Medicaid contracting reported by States implementing OBRA legislation compared to States with no implementation of OBRA legislation, there were differences between the numbers of barriers perceived by the State Medicaid Agencies and those perceived by the HMOs. Eighteen HMOs reported a total of 76 barriers while 20 State Medicaid Agencies reported a total of only 38 barriers - an average of 4.2 barriers reported per HMO to and average of 1.5 barriers reported per State. Barriers perceived most frequently by State Medicaid Agencies included the 75% Rule (35%), Contracting (25%), Medicaid Clients Considered Stigma (25%), and Other (60%). HMOs mentioned Turnover of Medicaid Clients (67%), Marketing (61%), Eligibility Determination (61%), Reimbursement Rates (56%), Slow Payment (39%), and Administrative Requirements (39%).

As each contracting situation is unique, it is difficult to determine if, and to what extent, the OBRA legislation is a contributing factor in reducing the problems encountered in HMO/Medicaid contracting. The legislation, especially the expansion of the definition of HMOs eligible to contract with Medicaid to include State-qualified HMOs, did allow and encourage more HMO/Medicaid contracts to develop, but how the legislation reduces barriers to contracting, can not yet be determined.

4. States Without HMO/Medicaid Contracts

Ten States without HMO/Medicaid contracts were contacted regarding plans of both the Medicaid Agencies and HMOs for contracting. HMOs and State Medicaid Agencies in four States agreed that they had current and/or future plans for HMO/Medicaid contracting. Three other State Medicaid Agencies stated that they had plans to contract in the future, but the interviewed HMOs in these three States did not plan to contract. The reasons that the State Medicaid Agencies gave for not contracting included that the Medicaid Agency was concentrating on other things (4), the HMO requirements were unacceptable (2), the geographic locations of the HMOs were not good (2), HMO contracting does not work (2), HMOs are not interested (1), and HMOs do not provide the level of care needed (1). HMOs' reasons for not contracting were: they were concentrating on other clients (6), they do not contract with the public sector (2), they are unfamiliar with the Medicaid population (2), and the State Medicaid Agency was not willing (1).

5. Enrollment

Medicaid enrollment in HMOs increased over the most recent two years for which data were available for almost all States whether the State Medicaid Agency had implemented OBRA legislation or not. Utah and Washington both showed an insignificant decrease of 1.5% (less than 100 people) while Indiana showed a larger decline (27.7%). Actual enrollment figures for 1983 compared to the most current year for which enrollment figures are available (1984 or 1985) increased from 176,404 to 324,385 - an increase of 84 percent. States using OBRA legislation increased enrollment ten times more than the States not using OBRA legislation. This difference can be explained principally by the fact that States using OBRA legislation were more likely to have just begun HMO/Medicaid contracting while the States not using OBRA legislation already have established HMO/Medicaid enrollments. For example, in Wisconsin, where OBRA legislation is used, over 100,000 enrollees were added to the HMO rolls through their mandatory choice program.

B. FUTURE IMPLICATIONS

HMO/Medicaid contracting and the implementation of OBRA legislative authorities is never stagnant. Changes are being continually considered by some States and are being implemented in other States. There are also competitive factors to be acknowledged such as Primary Care Case Management Systems, Health Insuring Organizations, and possible future regulations which could impact HMO/Medicaid contracting.

In terms of the initial impetus and the long-term results, the success of HMO/Medicaid contracting appears to be much more closely related to the political environment of the State than to any recent changes in Federal legislation. State Medicaid Agencies have been contracting with HMOs for years with varying results. Generally, when governors joined forces with State legislatures and State Medicaid Agencies carried out their mandate to contract with HMOs, the contracting was implemented in a timely manner, there were fewer problems, and there was greater success in terms of Medicaid enrollment. In some States, HMOs have approached State Medicaid Agencies about contracting but this usually has been a much slower process. Thus, it would appear that the lesson for HMOs that would like to contract with the Medicaid Agencies is to use the political process to influence State legislators and governors.

Some States have wanted to contract with HMOs in the past but either there were no HMOs in the State or the HMOs were not geographically located close to the Medicaid population. The increasing numbers of HMOs as well as the OBRA legislation allowing contracting with State-qualified HMOs has alleviated this problem for the most part. The use of State-qualified HMOs has been the most often implemented of the three legislative authorities examined in this study.

State Medicaid Agencies have been exploring alternative methods of service delivery in addition to HMOs. Frequently these alternatives have been pursued more vigorously than HMO contracting. More than a dozen States have received waivers under the 2175 authority to implement primary care case management (PCCM) systems. In most cases an HMO(s) has not been included as one of the case management providers. The simplest PCCM systems require Medicaid recipients to select a primary care physician or clinic, who then provides primary care directly and must authorize all inpatient care and referrals to specialists. Some of these systems pay the case manager a small "case management fee," typically $3 per enrollee per month, in addition to the standard FFS. There are no direct financial incentives to encourage cost-effective care in the basic systems. However, some States have built in some form of "shared savings" and/or capitation arrangement. Some of the States participating in PCCM projects are Kansas, Michigan, California, and Oregon.

Several States have also been interested in health insuring organizations (HIOs).[2] The State finds or establishes an organization that is willing to contract to pay for all or most acute care Medicaid services on an at-risk basis, and the State then requests a waiver for a PCCM system. Tennessee and California currently have HIO contracts, Pennsylvania is developing a HIO contract, and Kentucky formerly had a HIO contract. Kentucky's contract was cancelled due to political interest in establishing a state-wide case management system.

In summary, a number of States are aggressively pursuing enrollment of Medicaid recipients in traditional HMOs, using more flexible legislative authorities. Some of those same States and other States are pursuing an answer to the Medicaid budget constraints using PCCM projects and contracting with HIOs. As competition in the marketplace continues to increase, HMOs must be aware of these new competitive factors.

State legislators and Medicaid Agencies continue to make their pitch for expanded flexibility to run their Medicaid programs. In a recent meeting of the National Conference of State Legislatures changes in Federal Legislation were called for and one of those changes is directly related to this study: the restriction of recipient freedom-of-choice. In Wisconsin the Medicaid recipients in two counties are restricted in their freedom-of-choice. Wisconsin implemented a 2175 waiver to accomplish this and from no recipients enrolled in HMOs in 1983, over 100,000 recipients were enrolled by early 1985. Most States have not used the waiver process to restrict freedom-of-choice to HMOs but this is obviously an avenue that HMOs could affect which would impact HMO/Medicaid contracting.

Future changes in regulations will also affect HMO/Medicaid contracting. In order to qualify for Federal matching funds, State Medicaid Agencies must report certain program statistics on an annual basis. States currently have the option of submitting a hard copy report or a data tape. If the State selects the "Tape Option", the State is required to submit detailed encounter data from capitated plans. Most HMO data systems are not designed to capture individual utilization data. Thus, should the "Tape Option" become required, State Medicaid Agencies would have to require that any contracting HMOs be able to submit detailed encounter data. This could cause complications for both the HMOs and the State Medicaid Agencies.

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[2] HIOs are private organizations that serve as the State Medicaid Program's agent. The HIO contracts with the Medicaid agency on an at risk basis and is paid a fixed amount per recipient per month. The HIO is not itself a provider of care. The HIO contracts in turn with providers for services for Medicaid recipients.

CONCLUSIONS

This report is a compilation of the HMO/Medicaid contracting activities and not an evaluation of the effectiveness of the contracting process. Each HMO/Medicaid Agency is unique and what is effective for one may not be so for another. The effectiveness of the HMO/Medicaid contract lies in the established objectives and goals of the HMO and the Medicaid Agency. For example, for one HMO, their intention may be to serve just 10 percent of the Medicaid population in order to fulfill their committment of serving a cross section of the population. On the other hand, another HMO may view their HMO/Medicaid contract effective only if they are able to serve all Medicaid eligibles in their service area.

As previously mentioned, contracting was initiated more successfully when the political environment within the State encouraged contracting. The political environment of the State appeared more closely related to the success of HMO/Medicaid contract than to any recent changes in legislation. Generally, when the State Administration supported and encouraged HMO contracting, the contracting was implemented in a timely manner, there were fewer problems, and there was greater success in terms of Medicaid enrollment. In some States, HMOs have approached State Medicaid Agencies about contracting but this usually has been a much slower process.

HMO/Medicaid contracting and the implementation of OBRA legislative authorities is never stagnant. Changes are being considered by some States and are being implemented by other States. It was found that no matter what arrangement the States and HMOs have, they can learn from the experience of others as to the most effective ways to impact HMO/Medicaid contracting.

APPENDIX A: INTERVIEW GUIDES

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 1: States with 2175 Waiver and HMO contracts)

1. Please give the following descriptive information regarding each of the HMOs that you have contracted with:
   - Name of HMO
   - Geographic Area Served
   - Total Enrollment (by year)
   - Medicaid Enrollment (by year)
   - Years Contracted
   - Medicaid Population Served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they overcome?

4. How do you monitor HMOs?
   - Reporting Requirements
   - Site Visits

5. Describe the HMO reimbursement system under the Medicaid contract. How are rates set and how often?

6. What have been the results of Medicaid/HMO contracting in terms of :
   - Enrollment
   - Cost savings
   - Quality of care
   - Access to health care

   Do you have any studies documenting these results?

7. What barriers, if any, do you perceive to Medicaid/HMO contracting?

8. Describe the procedures for informing the HMO of the member's Medicaid eligibility. When is the HMO given this eligibility information?

9. To what degree do you aid HMOs in their efforts to market to Medicaid eligibles? What educational tools do you use to explain the HMO option?

10. How does the State Medicaid benefit package compare to the benefits offered by the HMOs?

11. Do you have any problems with the HMOs meeting the 75% rule? If yes, how do you plan to solve this dilemma?

12. Did any of the OBRA legislative changes (freedom-of-choice, 6-month guaranteed enrollment, contracting with alternative HMOs) have an influence on reducing the barriers to State/HMO contracting?

13. Do any of the HMOs you currently contract with operate under the waivers authorized in Section 1915(b) of the Social Security Act?
- If yes, please answer the following:

  - Why did you choose to apply for a freedom of choice waiver?
    - -Did any HMOs play a part in the decision process?
  - What type of freedom of choice waiver do you have?
  - What have been the results of HMO contracting under the freedom of choice waiver in terms of :
    - -Enrollment
    - -Cost savings
    - -Access
    - -Quality

-If no,have you considered this option and why did you not choose this option?

HMO INTERVIEW GUIDE

(Group 1: States with 2175 Waiver and HMO contracts)

1. Please give the following descriptive information regarding your HMO:
   - Name
   - Geographic Area Served
   - Years contracted with Medicaid
   - For years contracted with Medicaid (by year):
     - Total Enrollment
     - Medicaid Enrollment
   - Medicaid eligibility group served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. What were your main reasons for contracting with Medicaid?

4. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they resolved?

5. How is reimbursement to your HMO determined? Do you have data available on the actual costs of Medicaid recipients? Of your total enrollment? Is the Medicaid payment sufficient to cover your costs?

6. What barriers, if any, do you perceive in contracting with Medicaid?
   - Marketing
   - Eligibility determinations
   - Turnover of Medicaid recipients
   - Reporting requirements
   - Contracting
   - Payment
   - Administrative burden
   - Stigma of serving Medicaid population
   - 75% Rule
   - Rates
   - Other

7. If the state has a freedom-of-choice waiver, how has that waiver affected contracting with the state?

8. In your opinion, what have been the major factors leading to the current status of Medicaid enrollment in your HMO?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 2: States with extended eligibility)

1. Please give the following descriptive information regarding each of the HMOs that you have contracted with:
   - Name of HMO
   - Geographic Area Served
   - Total Enrollment (by year)
   - Medicaid Enrollment (by year)
   - Years Contracted
   - Medicaid Population Served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they overcome?

4. How do you monitor HMOs?
   - Reporting Requirements
   - Site Visits

5. Describe the HMO reimbursement system under the Medicaid contract. How are rates set and how often?

6. What have been the results of Medicaid/HMO contracting in terms of :
   - Enrollment
   - Cost savings
   - Quality of care
   - Access to health care

   Do you have any studies documenting these results?

7. What barriers, if any, do you perceive to Medicaid/HMO contracting?

8. Describe the procedures for informing the HMO of the member's Medicaid eligibility. When is the HMO given this eligibility information?

9. To what degree do you aid HMOs in their efforts to market to Medicaid eligibles? What educational tools do you use to explain the HMO option?

10. How does the State Medicaid benefit package compare to the benefits offered by the HMOs?

11. Do you have any problems with the HMOs meeting the 75% rule? If yes, how do you plan to solve this dilemma?

12. Did any of the OBRA legislative changes (freedom-of-choice, 6-month guaranteed enrollment, contracting with alternative HMOs) have an influence on reducing the barriers to State/HMO contracting?

13. Did you implement the 6-month guaranteed eligibility provision for HMO enrollment?
    -If so, please answer the following:

    - Why did you choose to implement the 6-month guaranteed eligibility?
    - What were the results of the guaranteed eligibility insofar as
        - -Willingness/desire of HMOs to contract with Medicaid before and after.
        - -Enrollment-disenrollment data.
        - -Cost savings/cost increases.

    -If no, did you consider it and why did you make the decision that you did?

HMO INTERVIEW GUIDE
(Group 2: States with extended eligibility)

1. Please give the following descriptive information regarding your HMO:
   - Name
   - Geographic Area Served
   - Years contracted with Medicaid
   - For years contracted with Medicaid (by year):
     - Total Enrollment
     - Medicaid Enrollment
   - Medicaid eligibility group served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. What were your main reasons for contracting with Medicaid?

4. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they resolved?

5. How is reimbursement to your HMO determined? Do you have data available on the actual costs of Medicaid recipients? Of your total enrollment? Is the Medicaid payment sufficient to cover your costs?

6. What barriers, if any, do you perceive in contracting with Medicaid?

   - Marketing
   - Eligibility determinations
   - Turnover of Medicaid recipients
   - Reporting requirements
   - Contracting
   - Payment
   - Administrative burden
   - Stigma of serving Medicaid population
   - 75% Rule
   - Rates
   - Other

7. If the state has/had a 6-month guaranteed enrollment provision, how did this affect the HMO?

8. In your opinion, what have been the major factors leading to the current status of Medicaid enrollment in your HMO?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 3: States that contract with State-Qualified HMOs)

1. Please give the following descriptive information regarding each of the HMOs that you have contracted with:
   - Name of HMO
   - Geographic Area Served
   - Total Enrollment (by year)
   - Medicaid Enrollment (by year)
   - Years Contracted
   - Medicaid Population Served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they overcome?

4. How do you monitor HMOs?
   - Reporting Requirements
   - Site Visits

5. Describe the HMO reimbursement system under the Medicaid contract. How are rates set and how often?

6. What have been the results of Medicaid/HMO contracting in terms of :
   - Enrollment
   - Cost savings
   - Quality of care
   - Access to health care

   Do you have any studies documenting these results?

7. What barriers, if any, do you perceive to Medicaid/HMO contracting?

8. Describe the procedures for informing the HMO of the member's Medicaid eligibility. When is the HMO given this eligibility information?

9. To what degree do you aid HMOs in their efforts to market to Medicaid eligibles? What educational tools do you use to explain the HMO option?

10. How does the State Medicaid benefit package compare to the benefits offered by the HMOs?

11. Do you have any problems with the HMOs meeting the 75% rule? If yes, how do you plan to solve this dilemma?

12. Did any of the OBRA legislative changes (freedom-of-choice, 6-month guaranteed enrollment, contracting with alternative HMOs) have an influence on reducing the barriers to State/HMO contracting?

13. Do you contract with any State-qualified (i.e.alternative) HMOs defined in Section 1903(m) of the Social Security Act? -If yes, please answer the following:

- Why did you choose to contract with State-qualified HMOs?
- What requirements(other than the two federal requirements) does the State place on State-qualified HMOs?
- What have been the results of contracting with State-qualified HMOs in terms of:
  - -Enrollment
  - -Cost savings
  - -Quality of care
  - -Access to health care

-If no, have you considered contracting with State-qualified HMOs and why have you chosen not to do so?

HMO INTERVIEW GUIDE
(Group 3: States that contract with State-Qualified HMOs)

1. Please give the following descriptive information regarding your HMO:
   - Name
   - Geographic Area Served
   - Years contracted with Medicaid
   - For years contracted with Medicaid (by year):
     - Total Enrollment
     - Medicaid Enrollment
   - Medicaid eligibility group served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. What were your main reasons for contracting with Medicaid?

4. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they resolved?

5. How is reimbursement to your HMO determined? Do you have data available on the actual costs of Medicaid recipients? Of your total enrollment? Is the Medicaid payment sufficient to cover your costs?

6. What barriers, if any, do you perceive in contracting with Medicaid?
   - Marketing
   - Eligibility determinations
   - Turnover of Medicaid recipients
   - Reporting requirements
   - Contracting
   - Payment
   - Administrative burden
   - Stigma of serving Medicaid population
   - 75% Rule
   - Rates
   - Other

7. If you are a State-qualified HMO, was it the OBRA 81 legislation that permitted you to contract with Medicaid? If not, what authority permitted the contracting?

8. In your opinion, what have been the major factors leading to the current status of Medicaid enrollment in your HMO?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 4: States with no HMO contracts under the
2175 Waiver but contract with HMOs)

1. Please give the following descriptive information regarding each of the HMOs that you have contracted with:
   - Name of HMO
   - Geographic Area Served
   - Total Enrollment (by year)
   - Medicaid Enrollment (by year)
   - Years Contracted
   - Medicaid Population Served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they overcome?

4. How do you monitor HMOs?
   - Reporting Requirements
   - Site Visits

5. Describe the HMO reimbursement system under the Medicaid contract. How are rates set and how often?

6. What have been the results of Medicaid/HMO contracting in terms of :
   - Enrollment
   - Cost savings
   - Quality of care
   - Access to health care

   Do you have any studies documenting these results?

7. What barriers, if any, do you perceive to Medicaid/HMO contracting?

8. Describe the procedures for informing the HMO of the member's Medicaid eligibility. When is the HMO given this eligibility information?

9. To what degree do you aid HMOs in their efforts to market to Medicaid eligibles? What educational tools do you use to explain the HMO option?

10. How does the State Medicaid benefit package compare to the benefits offered by the HMOs?

11. Do you have any problems with the HMOs meeting the 75% rule? If yes, how do you plan to solve this dilemma?

12. Did any of the OBRA legislative changes (freedom-of-choice, 6-month guaranteed enrollment, contracting with alternative HMOs) have an influence on reducing the barriers to State/HMO contracting?

HMO INTERVIEW GUIDE

(Group 4: States with no HMO contracts under 2175 Waiver but contract with HMOs)

1. Please give the following descriptive information regarding your HMO:
   - Name
   - Geographic Area Served
   - Years contracted with Medicaid
   - For years contracted with Medicaid (by year):
     - Total Enrollment
     - Medicaid Enrollment
   - Medicaid eligibility group served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. What were your main reasons for contracting with Medicaid?

4. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they resolved?

5. How is reimbursement to your HMO determined? Do you have data available on the actual costs of Medicaid recipients? Of your total enrollment? Is the Medicaid payment sufficient to cover your costs?

6. What barriers, if any, do you perceive in contracting with Medicaid?

   - Marketing
   - Eligibility determinations
   - Turnover of Medicaid recipients
   - Reporting requirements
   - Contracting
   - Payment
   - Administrative burden
   - Stigma of serving Medicaid population
   - 75% Rule
   - Rates
   - Other

7. In your opinion, what have been the major factors leading to the current status of Medicaid enrollment in your HMO?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 5: States with OBRA legislative authority
and no HMO contracts)

1. Does your agency currently contract with HMOs for Medicaid recipients or have plans to do so in the future? Why/Why not?

2. Does your State Medicaid agency have a waiver of freedom of choice under Section 1915(b) of the Social Security Act? If yes, did you consider using it as a vehicle to contract with HMOs or other organizations? Explain.

HMO INTERVIEW GUIDE

(Group 5: States with OBRA legislative authority
and no HMO contracts)

1. Name of your HMO

2. Does your HMO have any current or future plans to contract with the State Medicaid Agency? Why/why not?

3. What are your main reasons for not contracting with the State Medicaid Agency?

4. Your State has implemented the freedom of choice waiver under Section 1915(b) of the Social Security Act. If you decided to contract with the State Medicaid Agency, would you like to see the incorporation of this waiver into your HMO/Medicaid contract?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 6: States with no OBRA legislative authority but contract with HMOs)

1. Please give the following descriptive information regarding each of the HMOs that you have contracted with:
   - Name of HMO
   - Geographic Area Served
   - Total Enrollment (by year)
   - Medicaid Enrollment (by year)
   - Years Contracted
   - Medicaid Population Served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they overcome?

4. How do you monitor HMOs?
   - Reporting Requirements
   - Site Visits

5. Describe the HMO reimbursement system under the Medicaid contract. How are rates set and how often?

6. What have been the results of Medicaid/HMO contracting in terms of :
   - Enrollment
   - Cost savings
   - Quality of care
   - Access to health care

   Do you have any studies documenting these results?

7. What barriers, if any, do you perceive to Medicaid/HMO contracting?

8. Describe the procedures for informing the HMO of the member's Medicaid eligibility. When is the HMO given this eligibility information?

9. To what degree do you aid HMOs in their efforts to market to Medicaid eligibles? What educational tools do you use to explain the HMO option?

10. How does the State Medicaid benefit package compare to the benefits offered by the HMOs?

11. Do you have any problems with the HMOs meeting the 75% rule? If yes, how do you plan to solve this dilemma?

12. Have you ever considered implementing any of the OBRA legislative changes?

HMO INTERVIEW GUIDE

(Group 6: States with no OBRA legislative authority but have HMO contracts)

1. Please give the following descriptive information regarding your HMO:
   - Name
   - Geographic Area Served
   - Years contracted with Medicaid
   - For years contracted with Medicaid (by year):
     - Total Enrollment
     - Medicaid Enrollment
   - Medicaid eligibility group served

2. What/who gave impetus to the Medicaid/HMO contracting process?

3. What were your main reasons for contracting with Medicaid?

4. How are contracts developed between States and HMOs? Were there any problems in the development or implementation of the contracts? If so, how were they resolved?

5. How is reimbursement to your HMO determined? Do you have data available on the actual costs of Medicaid recipients? Of your total enrollment? Is the Medicaid payment sufficient to cover your costs?

6. What barriers, if any, do you perceive in contracting with Medicaid?

   - Marketing
   - Eligibility determinations
   - Turnover of Medicaid recipients
   - Reporting requirements
   - Contracting
   - Payment
   - Administrative burden
   - Stigma of serving Medicaid population
   - 75% Rule
   - Rates
   - Other

7. Does your HMO desire your State to make use of the OBRA legislative changes?

8. In your opinion, what have been the major factors leading to the current status of Medicaid enrollment in your HMO?

STATE MEDICAID AGENCY INTERVIEW GUIDE

(Group 7: States with no OBRA legislative authority
and no HMO contracts)

1. Does your agency currently contract with HMOs for Medicaid recipients or have plans to do so in the future? Why/Why not?

2. Does your State Medicaid agency have a waiver of freedom of choice under Section 1915(b) of the Social Security Act? If yes, did you consider using it as a vehicle to contract with HMOs or other organizations? Explain.

3. What are your main reasons for not contracting with any HMOs?

4. Would you consider contracting if an HMO approached you for contracting?

HMO INTERVIEW GUIDE

(Group 7: States with no OBRA legislative authority
and no HMO contracts)

1. Name of your HMO
2. Does your HMO have any current or future plans to contract with the State Medicaid Agency? Why/Why not?
3. What are your main reasons for not contracting with the State Medicaid Agency?
4. Would you contract if given the opportunity by the State Medicaid Agency?

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